

HIV AND HEPATITIS IN SPORTS: AN AUSTRALIAN LEGAL FRAMEWORK FOR RESOLVING HARD CASES¹

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I. INTRODUCTION

The profile of HIV and hepatitis in sports has risen dramatically in recent years. A number of incidents and reports have highlighted that HIV, in particular, has a sporting dimension. For example, on November 7, 1991, the outstanding and idolized United States professional basketball player, Earvin ('Magic') Johnson, of the Los Angeles Lakers, announced that he had HIV, having contracted it through heterosexual contact.⁴ Johnson retired immediately, only to indicate within a few months that he was willing and able to compete on the United States team at the Olympic Games held in Barcelona in 1992. His selection for the so-called 'Dream Team', comprised of professional basketball players alike, was a foregone conclusion. However, an international furor erupted when some Australian basketball players questioned whether they were at risk of contracting HIV by playing against Johnson.⁵

In April 1992, Arthur Ashe, the 1975 Wimbledon champion, revealed that he was suffering from AIDS. He had known that he had HIV since 1988, but made the announcement of his condition to forestall its imminent reporting in the media. Ashe probably contracted HIV in 1983 from a blood transfusion administered in connection with heart bypass surgery.⁶

In November 1992, it was reported that three world class Canadian figure skaters had died of AIDS in the previous 12 months.⁷

Issues of infectious diseases in sports have also arisen in Australia.⁸ In July 1992, a Tasmanian Australian rules football player

4. SPORTS ILLUSTRATED, Nov. 18, 1991, at 16.

5. *Fury in US at Call to Boycott Magic*, THE AGE, Jan. 1992, at 25.; *AIDS Risk in Sport Proved Claim Doctors*, THE ADVERTISER Jan. 28, 1992, at 8.; *After the Ridicule, Borner's Views Supported*, THE AGE, Nov. 11, 1992.; J Niall, *AIDS in Sport* INSIDE SPORT, Apr. 1993, at 14.

6. SPORTS ILLUSTRATED, Dec. 21, 1992, at 16.

7. *Ice-skating in Crisis as Top Stars Confront AIDS*, THE AGE Nov. 20, 1992, at 4.; *see also Skater Remained True to His Form*, THE AUSTRALIAN Apr. 20, 1994 at 5.

8. Australia, like the United States, is a federation consisting of a federal government, six States (New South Wales (NSW), Victoria (Vic), Queensland (Qld), South Australia (SA), Western Australia (WA) and Tasmania (Tas)) and several territories including the Australian Capital Territory (ACT) and Northern Territory (NT).

Sports are an important part of Australian culture. A wide range of individual and team sports is played in Australia both at amateur and professional levels. Individual sports include golf, tennis, track and field, swimming, martial arts and boxing. Team sports have tended to be divided into winter and summer sports. The two main winter sports have been Australian Rules football and rugby league. At a professional level these are organized into national leagues, although each sport has had geographic strongholds (Australian Rules football in Victoria, South Australia, Western Australia and Tasmania and rugby league in New South Wales and Queensland). There are regional minor leagues in each State. Soccer

was banned from playing the sport by the Tasmanian North-East Football Union because he had contracted HIV. It was reported that the Union also withdrew registration of players who had tested positive for Hepatitis B or C.⁹

Science has known of HIV for a decade and of hepatitis for much longer. So, it may seem surprising that these incidents and reports should have attracted such sensational treatment in the mass media. There are, perhaps, three reasons for this treatment. First, the prospect of transmission of these viruses (especially HIV) via sporting activity has not received significant attention either in medicine or the mass media. Second, the traditional high-risk groups for transmission of HIV (male homosexuals, intravenous drug users and haemophiliacs) do not play, or are not perceived as players of, contact sports in particular.¹⁰ Third, these incidents sharpened the emerging realization that HIV was a more general health threat which could not be dismissed on the basis that only marginalized groups were at risk.

HIV and hepatitis are not, of course, the only infections which may be transmitted in sports. Colds, influenza, impetigo, tinea, herpes simplex and herpes zoster (chickenpox) are just some of the communicable and infectious diseases which may be transmitted, especially in physical contact sports.¹¹ However, the valuable consequence of media attention on HIV in sporting contexts has been to bring home to various sectors of the community, the need for effective action to control the transmission of infectious diseases.

We will examine the issues from the viewpoint of a sports organization seeking to develop and implement an infectious diseases policy which both minimizes the risk of disease transmission and the prospect of legal liability for such transmission. Part 2 will

developed as a major sport in Australia as a result of post World War II immigration and there is a National Soccer League. It plays a summer fixture to avoid competition with the other football codes. Basketball has emerged as a popular winter sport over the past decade and a men's National Basketball League has the widest geographic coverage of any national sports league in Australia. A women's semi-professional basketball league has a smaller following and geographic spread, but is overshadowed by the very popular netball which has a developing national competition.

Cricket is the dominant summer team sport. It is played professionally at international and interstate levels with separate minor league competitions in each State capital city. There is a growing but small semi-professional baseball league. Major amateur team sports include field hockey, softball and rugby union. There is no collegiate sports competition comparable to the NCAA. Instead, there is strong community sport participation.

9. *HIV-Positive Footballer Banned*, THE AGE, July 17, 1992; *Council Slates HIV Sport Ban* THE AUSTRALIAN July 17, 1992, at 3; *Top Footy Hope has AIDS!*, TRUTH, June 6, 1992.

10. See *The Full Implications of Martial Arts Legislation*, 14(3) AUSTRALASIAN FIGHTING ARTS 70 (1991).

11. R.W.A. Girdwood, *Infections Associated with Sport*, 22 BRITISH JOURNAL OF SPORTS MEDICINE 117 (1988); *Wrestling's Risk*, THE HARTFORD COURANT, Feb. 21, 1992.

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

The aim of our discussion is to provide a framework for analysis of the practical legal problems that possible disease transmission in sport creates, and to provoke informed debate. The legal doctrines discussed (duty of care, discrimination, restraint of trade, confidentiality), each have their own internal logic and history of application. We believe that there is potential for conflict between the interests of protection from bodily harm, respect for the privacy of personal health information and the elimination of discrimination. Not only must these tensions be resolved so that sports may be pursued under a clear legal framework, but, in the process of finding a resolution, we believe some light may be shed on the legal issues surrounding infectious diseases in the broader community context. As far as Australia is concerned, we believe that an immediate legislative resolution to these sports law issues is highly unlikely. In applying legal doctrines to the novel context of disease transmission in sports, we have steered a course which some may consider controversial.¹² Those who would apply doctrines such as duty of care or discrimination differently, however, should bear in mind the potential for conflict which we have largely avoided. In this emotive area, the application of legal doctrine to the disease transmission context is made doubly difficult by present statistical and medical uncertainty over sports-related transmission. We recognize that as more medical evidence emerges, the application of the legal principles we identify may lead to different outcomes.

12. After this paper was presented at the Third Annual ANZSLA Conference at Canberra on Dec. 4, 1993, it attracted some critical comment; see e.g. *Call for HIV Tests in Contact Sports*, THE SYDNEY MORNING HERALD, Dec. 6, 1993.

II. THE RELATIONSHIP BETWEEN HIV, HEPATITIS AND SPORTS

Sports administrators and their advisers, athletes and other involved in the organization of sports that involve physical contact each share the common goals of (1) preventing the transmission of HIV/Hepatitis within sporting contexts and (2) avoiding legal liability for such transmission. The potential legal problems arising from HIV/hepatitis in sports arise from, and are limited by, the manner and likelihood of HIV/hepatitis transmission in sports-related contexts. Administrators, athletes and others must put aside personal prejudices, myths and misinformation when considering what action the risk of transmission within their sport requires. Legal, political and policy responses to infectious diseases in sports must be based on scientific fact.

A. Means and Evidence of Transmission of HIV and Hepatitis in Sports

1. Human Immunodeficiency Virus

HIV infection initially causes an acute viral infection from which subjects invariably recover. Thereafter, the infected subject may suffer no further symptoms for an average of 8 years or more.¹³ While cases of long term symptomless infection suggest that there may be less virulent strains of HIV,¹⁴ It is well known that, on the current level of knowledge, HIV infection will inevitably, after a period of years, progress to AIDS. AIDS refers to the onset of life-threatening illnesses caused by the collapse of the body's immune resistance as a result of HIV infection. The more important examples of these illnesses (often referred to as AIDS-defining illnesses) are pneumonias, opportunistic infections, malignancies and neurological illnesses.¹⁵

HIV may be transmitted sexually (by penetrative vaginal, anal and possibly oral sex¹⁶ involving exchange of body fluids), perinatally, by the transplantation of infected tissue, and by the direct inoculation of infected blood,¹⁷ whether by IV drug use, blood trans-

13. N. Crofts, *Patterns of Infection*, AIDS IN AUSTRALIA (1992) at 28.

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

15. A. Carr, *What is AIDS?*, AIDS IN AUSTRALIA at 3, 7-8 (1992). The mean survival time for patients with AIDS-defining illnesses is 2 to 3 years. There are, as yet, no effective vaccines against HIV. Today, 17,568 Australians have been diagnosed as HIV positive, with 4,530 cases of AIDS resulting in 3,017 deaths. Cumulative diagnoses reported to the National Centre in HIV Epidemiology and Clinical Research, St. Vincent's Hospital, Sydney. The figures are taken from *Australian HIV Surveillance Report*, Vol. 10, No. 1 (Jan. 1994), Table 2.1

16. *AIDS Study Leaves Open Verdict on Oral Sex*, THE AGE, Jan. 29, 1994.

17. Crofts, *supra* note 13, at 29-32.

fusions, needlestick injuries or potentially, by bloody contact between athletes participating in sports.¹⁸ Although HIV has been isolated in other body fluids such as saliva and tears,¹⁹ there is no evidence that HIV may be transmitted by ordinary casual or household contact (shaking hands, sharing drinking glasses, using toilet seats, hugging).²⁰ Over ten years into the epidemic, in the absence of any reported instances, it appears that HIV cannot be transmitted through contact with the sweat or spit of an infected person, or by ordinary physical contact during sporting events, training or physiotherapy not involving blood contact.²¹ There have, however, been isolated reported examples of HIV transmission following a collision on a soccer field which caused severe skin wounds with copious bleeding.²² In another case, a bodybuilder acquired HIV and hepatitis B as a result of sharing needles with other bodybuilders who were all injecting anabolic steroids.²³

2. Hepatitis B (HBV)

In view of the fact that HIV is relatively difficult to transmit, hepatitis presents a far more serious picture. HBV is an escalating problem in Australia. HBV infection follows either of two pathways. *Acute* HBV may be symptomless, or it may cause fever, vomiting, jaundice and other symptoms which frequently require weeks or months of hospitalization before full recovery. The death rate from acute HBV is less than 1%, with most cases becoming non-infectious in three to six months.²⁴

18. *Australian HIV Surveillance Report*, Vol 10, No 1 (Jan. 1994) Table 2.2. To date, 81.5% of infections have been attributed to male homosexual/bisexual contact, with intravenous drug use (both alone and with homosexual/bisexual contact) accounting for a further 8.1%. Heterosexual contact accounts for 6.4% of infections. *Id.*

19. J. E. Groopman, S. Z. Salahudin et al., *HTLV-III in Saliva of People with AIDS-Related Complex and Healthy Homosexual Men at Risk for AIDS*, 226 *SCIENCE* 447 (1984); L.S. Fujikawa, S. Z. Salahuddin et al., *Isolation of Human T-Lymphotropic Virus Type III from the Tears of a Patient with Acquired Immunodeficiency Syndrome*, 2 *THE LANCET* 529 (1985).

20. G. H. Friedland, B. R. Saltzman, M. F. Rogers, et al., *Lack of Transmission of HTLV-III/LAV Infection to Household Contacts of Patients with AIDS or AIDS-Related Complex with Oral Candidiasis*, 314 *THE NEW ENGLAND JOURNAL OF MEDICINE* 344 (1986).

21. *World Health Organization and International Federation of Sports Medicine Consensus Statement from Consultation on AIDS and Sports* (1989) (hereinafter *WHO Consensus Statement*).

22. *Transmission of HIV-1 Infection Via Sports Injury*, 335 *THE LANCET* 1105 (1990). The source of transmission has, however, been questioned: F. M. Goldsmith, *When Sport and HIV Share the Bill, Smart Money Goes on Common Sense*, 267 *JAMA* 1311 (1992).

23. *AIDS in a Bodybuilder Using Anabolic Steroids*, 311 *NEW ENGLAND JOURNAL OF MEDICINE* 1701 (1984).

24. E. Walker, *Herpes Simplex, Hepatitis B and the Acquired Immune Deficiency Syndrome in Infections in Sport* (*Proceedings of the Sports Medicine Conference organised by the*

Chronic HBV, however, may be a symptomless infection which progresses insidiously, leading to liver cancer, cirrhosis and other lethal illnesses.²⁵ Persons infected as children are much more likely to become carriers than those infected as adults. Carrier infectivity falls over time.²⁶

HBV is present in blood and all body fluids of infected persons. The most efficient means of HBV transmission is vertically, from mother to child.²⁷ HBV may also be transmitted sexually, through infected blood or semen, and by inoculation with infected blood and body fluids.²⁸ While this includes transmission through needle sharing, needlestick injuries, blood transfusions and renal dialysis, HBV may also be transmitted by splashing infectious fluids onto mucous membranes,²⁹ and through relatively minor cases of inoculation through the skin; for example, by sharing razors.³⁰ HBV transmission has been documented after accidents, where infected blood comes in contact with cuts and abrasions of the skin.³¹ Unlike HIV, which is thought to rapidly succumb upon exposure to open air, HBV may survive outside of the human body for some hours; thus surfaces may become 'contaminated'.³² Finally, unlike

Edinburgh Post-Graduate Board for Medicine 4 March 1988), 22 BRITISH JOURNAL OF SPORTS MEDICINE 117, 119 (1988).

25. See D. H. Campbell, A. J. Plant, J. W. Sargent, et al., *Hepatitis B Infection of Children in a Mixed Race Community in Western New South Wales*, 154 MEDICAL JOURNAL OF AUSTRALIA 253 (1991). In Australia, as in Northern Europe and the United States, at least 0.1% of the population are estimated to be chronic carriers of HBV capable of transmitting infection, although the carrier rate is unevenly distributed, being much higher in some ethnic communities, and especially so in aboriginal communities where studies have estimated carrier rates at between 10% and 25%. I. D. Gardner, X. Wan, P. A. Simms, et al., *Hepatitis B Virus Markers in Children and Staff in Northern Territory Schools*, 156 MEDICAL JOURNAL OF AUSTRALIA 638 (1992); C. J. Burrell, A. S. Cameron, G. Hart, et al., *Hepatitis B Reservoirs and Attack Rates in an Australian Community* 2 MEDICAL JOURNAL OF AUSTRALIA 292 (1983).

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

27. I. D. Gust, *Control of Hepatitis B in Australia*, 156 MEDICAL JOURNAL OF AUSTRALIA 819 (1992).

28. See R. Nisini, and M. Rizzetto, *Clinical Types of HSAg-Positive Hepatitis*, 11 VACCINE 511 (1993); E. Fagan, and R. Williams, *Hepatitis Caused by Hepatitis B Virus*, 231 THE PRACTITIONER 371 (1987).

29. E. Reiss-Levy et al., *Acute Fulminant Hepatitis B Following a Spit in the Eye by a Hepatitis B e Antigen Negative Carrier*, 160 MEDICAL JOURNAL OF AUSTRALIA 524 (1994).

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

31. G.H. Radvan, D.G. Hewson, S. Berenger, et al., *The Newcastle Hepatitis B Outbreak*, 144 MEDICAL JOURNAL OF AUSTRALIA 461 (1986).

32. M. Piazza, V. Guadagnino, et al., *Contamination by Hepatitis B Surface Antigen in Dental Surgeries*, 295 BRITISH MEDICAL JOURNAL 473 (1987); E. Walker, *supra* note 23. An outbreak of Hepatitis B amongst Swedish cross-country runners, for example, was thought to have resulted from competitors cutting and grazing themselves as they navigated untracked woodland, leaving blood adhering to the scrub which later competitors grazed

HIV, a vaccine exists for HBV which provides high immunity at least in the short term.³³ Vaccination of health care workers has been recommended and is clearly one way of decreasing HBV transmission in sports.

3. Hepatitis C (HCV)

HCV was first identified in 1988. It is now thought to account for the majority of 'non-A/non-B' hepatitis infections, and in fact to be more common than other hepatitis viruses. It has been estimated that there are five times as many people infected with HCV as HIV, with 15 times as many new infections occurring each year.³⁴

There is no vaccine against HCV, nor does previous infection appear to grant immunity to subsequent bouts of acute HCV. HCV was responsible for 90% of post-transfusion hepatitis, although the introduction of HCV screening of blood donations since 1990 now makes this a minimal risk. The sharing of contaminated injecting equipment among injecting drug users is the major factor associated with transmission in Australia.³⁵

B. Relative Risk of HIV/Hepatitis Transmission in Sports

1. Relevant Variables

The risk of HIV transmission in sports arises, therefore, whenever an uninfected player, official or doctor is inoculated with the

against, and by communal bathing at the finish line. J.W. Sheridan, *supra* note 26.

33. I.D. Gust, *supra* note 27, at 820.; R. Nisini and M. Rizzetto, *supra* note 28, at 514; E. Fagan and R. Williams *supra* note 28, at 373-77.

34. A. Wodak and N. Crofts, *Responding to the Spread of Hepatitis C in Australia*, paper delivered at the *National Symposium on Hepatitis C*, Oct. 1993, St. Vincent's Hospital, Melbourne. While it has been estimated that 10% of adult patients contracting HBV, and 98% of newborn children contracting HBV will remain chronic carriers, it appears that virtually all persons with acute HCV infection will become chronically infected, leading to chronic liver disease in an average of 67%. On the limited knowledge, it is established that many of those with chronic HCV will develop liver disease, with at least 20% progressing to cirrhosis within 20 years. K. Watson, *Hepatitis C Infection in Australia*, 18 MODERN MEDICINE OF AUSTRALIA 26 (July 1991).

35. C.K. Fairley, D.E. Leslie, et al., *Epidemiology and Hepatitis C Virus in Victoria*, 153 MEDICAL JOURNAL OF AUSTRALIA 271 (1990). Overall, about two-thirds of current IDU's have been exposed to HCV, rising to over 90% of people who have injected drugs for more than five years. A. Wodak and N. Crofts, *supra* note 34. In contrast to HBV, sexual transmission of HCV is considered low, as is household or social transmission, although community-acquired HCV has been documented, with no known route of infection. K. Watson, *supra* note 34. In one Australian study, moderate HCV prevalence was found among homosexuals attending a sauna (34.1%), prisoners (30.8%), female prostitutes (10.4%), and homosexual men requesting HIV testing (8.8%). C. K. Fairley, D. E. Leslie, et al., *Epidemiology and Hepatitis C Virus in Victoria*, 153 MEDICAL JOURNAL OF AUSTRALIA 271 (1990).

blood of an infected player. Theoretically, this may occur whenever a 'bleeding skin wound on an HIV-infected person . . . comes into contact with or rubs against an open lesion on the skin of the uninfected opponent.'³⁶ In addition, a risk of HBV/HCV transmission may arise where infected blood or body fluids come in contact with broken skin, lesions, or membranous tissues of an uninfected player. It should be emphasized, however, in that so far as there is a risk, it will exist not only for opponents, but also for other members of the team to which the infected player belongs and for first aid-workers, trainers, and sports doctors treating injuries. The risk may be greatest for teammates, who both train and play regularly with the infected player.

As in the case of occupational transmission of infectious diseases within medical settings, it is perhaps ironic that recent concern over transmission in sports has been sparked by HIV, even though hepatitis is far more infectious, and in the case of needlestick injuries, is responsible for many more deaths each year. There has been little study calculating the risk of transmission in sporting contexts. While the risk is certainly low, it is not zero.³⁷

36. C. Loveday, *HIV Disease and Sport*, MEDICINE, SPORT AND THE LAW, at 81, 83 (1990).

37. See *AIDS Risk in Sport Proved, Claim Doctors*, THE ADVERTISER, Jan. 28, 1992, at 8; see also *WHO Consensus Statement* (1989); J.W. Sheridan, *supra* note 26, at 464. Sheridan has argued that the risk of acquiring a blood-borne infection will depend upon the following variables: (1) the estimated carriage rate of the infection in the participants; (2) the estimated chance of blood to abrasion or blood to mucous membrane exposure; (3) the infectiousness of the disease; and (4) the presence or absence of protective immunity. *Id.*

The carriage rate of the disease will be influenced by lifestyle (homosexual men at greatly increased risk of HIV/HBV; injecting drug users sharing equipment at high risk of HCV); ethnicity (high prevalence of HBV in some ethnic groups); gender (in Australia, HIV is far more common in males; HBV infection more likely to be chronic in males) and blood transfusion history. The chance of blood to abrasion or blood to mucous membrane exposure will be influenced by the nature of the sport, protection measures and equipment, first aid procedures, age of the participants (children may be less aggressive, and thus less prone to injury) and behavior as modified by health education and the rules of the sport. Obviously, the number of possible permutations is virtually limitless. Calculations of risk would also have to take into account circumstances such as the increased exposure over time of teammates of a carrier (relevant in sports where collisions occur) and the varying levels of exposure during a single contest (greater for an opponent matched against a carrier, lesser for an infrequently used substitute). *Id.* at 467.

On the assumption that blood to abrasion transmission in sports carries a similar risk to transmission by needlestick injury, Sheridan has suggested that, in a hypothetical contact sport played responsibly by men in their twenties, whose infection rates are typical of the population, 1.0% of the participants would have HBV, 1.0 % would have HCV, and .25% would have HIV. Assuming that each individual's chance of blood to abrasion contact was one in 50 games, and that contact caused infection in 25% of HBV cases, 16% of HCV cases and 0.5% of HIV cases, Sheridan calculates that the risk of acquiring an infection per game would be 1/20,000 for HBV, 1/31,500 for HCV and 1/4,000,000 for HIV. In a hypothetical situation involving the same sport played by participants from an ethnic group with high (10%) HBV carriage rates, the risk per game of acquiring HVB would be 1/2,000, with a 1/40,000 chance

2. Combat, Contact, Collision and Non-Contact Sports

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

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

In *contact* sports, such as rugby league, rugby union and Australian rules football, aggressive physical contact is permitted under the rules and occurs continuously throughout the game, although the object of the sport is not the physical suppression of other players, but something else, such as the scoring of goals or tries. Again, while 'blood-bin' policies may be helpful in lowering the risk of blood contact after an initial injury, the players involved in the tackle or incident producing the initial injury will not be protected if infected players are participating in the sport.³⁸

In *collision* sports, by contrast, direct physical aggression or contact between players is not permitted or is severely restricted, although it is still inevitable or inherent in the sport. In soccer, basketball, hockey, volleyball, and cricket, for example, bloody collisions do occur, with greater or lesser frequency, although such

of chronic infection assuming 5% of infections progressed to chronicity. In a final hypothetical situation in which 25% of participants have used intravenous drugs, 2% have HBV, 20% have HCV and 5% have HIV, and where the chance of blood to abrasion contact is once every four contests, the risk of acquiring an infection per contest would be 1/800 for HBV, 1/125 for HCV and 1/16,000 for HIV. In this situation, assuming that 5% of HBV infections, 25% of HCV infections and all HIV infections become chronic, Sheridan estimates that the risk per individual per sports contest of becoming chronically infected would be 1/16,000 for HBV, 1/800 for HCV and 1/16,000 for HIV. *Id.*

38. H. Seward, J. Orchard, H. Hazard, and D. Collinson, *Football Injuries in Australia at the Elite Level*, 159 *MEDICAL JOURNAL OF AUSTRALIA* 298 (1993). A recent study reported that head and facial lacerations were the most common injuries in rugby league and union played at the elite level (11% and 20%, respectively). *Id.*

sports are sometimes referred to as 'non-contact' sports. The Magic Johnson episode, and the fear expressed by Australian Olympic basketball players, and later by NBA basketball players, about playing against Johnson reflect the fear of HIV transmission even in sports where physical contact is not an ordinarily accepted part of the game.³⁹ This comment, made at the height of controversy over Magic Johnson's proposed Olympic participation, reflects the uncertainty over the risk of HIV transmission.

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

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

3. The Analogy with HIV/HBV Occupational Transmission

The relative risk of bloody contact between participants in a sport, or between players and trainers or doctors, must be distinguished from the risk of HIV/hepatitis transmission as a result of such an incident. The risk of HIV/hepatitis transmission through needlestick injuries exists in medical contacts.⁴⁰ In Australia, recent studies have concluded that the risk of acquiring HIV through occupational exposure is very low,⁴¹ although there have been sev-

39. See *Fear, Not Reason, Pushed a Legend into Retirement*, THE AGE, Nov. 7, 1992; *After the Ridicule, Borner's Views Supported*, THE AGE Nov. 11, 1992.; *AIDS in Sport*, THE SUNDAY AGE, Feb. 2, 1992, at Sport 11. Dr. Ian Gust, chief medical adviser to the Australian federal government on AIDS, has said that the chance of contracting HIV playing basketball is about 'the same as being kicked to death by a duck.' However, 'you have to be honest and say it can happen but it seems to be extraordinarily rare . . . 'Id.

40. See J. Elford, R. Moodie, A. McDonald, et. al., *The VII International Conference on Aids - A Report from Amsterdam*, *Australian HIV Surveillance Report*, Vol 8, Supp 3, July 1993, 5. In June 1991, it was estimated that some 30-60 health care workers worldwide had been infected with HIV following occupational exposure. *Id.*

41. Recent studies include: D. Marriott, a. McDonald, G. dolan, et al., *Characteristics of Occupational Exposures to Blood and body Fluids at St. Vincent's Hospital, Sydney*, AUSTRALIA

eral documented cases of HIV transmission from patient to health care worker following needlestick injuries.⁴² Although occupational transmission of HIV has occurred, as a percentage of total health care worker/patient contacts, the risk of transmission is exceedingly low.⁴³

Some allowance must obviously be made for differences in kind of blood contact which may take place in a medical context (for example, a needlestick with a syringe containing infected blood), and in a sports context (for example, a hard tackle in a rugby game involving facial cuts and abrasions to both players, and freely flowing blood). The fact that sports-related transmission is not more frequent may reflect the fact that while a needlestick transports infected blood directly beneath the skin, a collision causing blood contact between two athletes would cause both of them to bleed out, rather than bleed in.⁴⁴ Trainers or sports doctors providing medical assistance to infected athletes would obviously run the usual

LIAN HIV SURVEILLANCE REPORT, VOL. 7, SUPP. 4, OCT. 1991; D. Mallon, w. Shearwood, S. Mallal, et al., *Exposure to blood borne Infections in Health Care Workers*, 157 MEDICAL JOURNAL OF AUSTRALIA 592 (1992); F. Bowden, B. Pollett, et al., *Occupational Exposure to the Human Immunodeficiency Virus and Other Blood-borne Pathogens: A Six Year prospective Study*, 158 MEDICAL JOURNAL OF AUSTRALIA 810 (1993).

42. *Woman Health Worker Catches AIDS Virus from Patient*, THE AGE, May 1, 1989, at 1; *Health Care Worker contracts HIV*, THE WEEKEND AUSTRALIAN, July, 1992, at 18-19. The Royal Australasian college of Surgeons claims that four nurses, one ambulance officer, one prison warden and one Resident Medical Officer have reported with occupationally acquired HIV. Royal Australasian College of Surgeons, Policy Document, *Infection Control in Surgery and Management of AIDS (HIV) and Hepatitis B*, 1994, at 14.

43. L. Gostin, *Hospitals, Health Care Professionals, and AIDS: The 'Right to Know the Health Status of Professionals and Patients*, 48 MARYLAND L. REV. 12, 17 (1988). Gostin has summarized the issue as follows:

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

Id. This statement suggests that HIV can be transmitted by mucous membrane exposure. It therefore suggests an additional means of transmission to those discussed above in Section 2 (a)(i). Gostin refers to three cases where health care workers acquired HIV through substantial exposure of blood to mucous membrane and broken skin, but regards these cases as highly unusual. *Id.* at 17-18.

The United States Centre for Disease Control has estimated that 12,000 health care workers are infected with HBV each year by exposure to patients' blood, resulting in 250 deaths annually. HBV, rather than HIV, is thus the major occupational disease for health care workers. N. Daniels, *HIV-Infected Health Care Professional: Public Threat or Public Sacrifice?*, 70 THE MILBANK QUARTERLY 3, 14 (1992).

44. M. J. Mitten, *AIDS and Athletics*, 2 SETON HALL J. SPORT L. 5, 10 (1993) (citing *Sports Illustrated*, Nov. 30, 1992, at 13).

risk of occupational HIV/hepatitis transmission, as discussed above. For players, however, the relative lack of documented cases of transmission of HIV, at least, is very low.

Players are far more likely to catch HIV/HBV/HCV from sexual encounters or recreational drug use than from bloody collisions while playing sports. In the Australian Football League (AFL)⁴⁵, for example, this has led to the setting up of a pilot program which aims to educate players about sexually transmitted diseases, thereby influencing behavior. In America, it has been suggested that the incidence of infectious diseases may be higher in professional athletes than in the general population; in view of the 'fast-lane lifestyles' of some athletes.⁴⁶ Education programs detailing the risks of infection transmission on and off the field are an integral part of a reasoned policy response to the risk of transmission in sports.

III. CURRENT INFECTION CONTROL POLICIES IN AUSTRALIAN SPORTS

The risk of HIV/HBV/HCV transmission in sports may be low, but it is not zero, and its potentially tragic consequences, together with possible legal liability, justify the development and implementation by sporting organizations of considering infectious diseases policies.⁴⁷ The *Infectious Diseases Policy* of the Australian Sports Medicine Federation (ASMF), together with the draft *Guidelines for Sports on Infectious Diseases* under preparation by the ASMF Infectious Diseases in Sport Working Party, are consistent with this approach to infection control. The ASMF policy advocates strict personal hygiene, recommends HBV vaccination for athletes playing contact/collision sports under adult rules, prohibits the sharing of towels, razors, drink containers, and similar items, and requires that all cuts and abrasions be reported to medical staff. The policy advocates a 'blood-bin' procedure⁴⁸ which requires that all bleeding

45. The AFL is the national professional league for Australian Rule for football.

46. See M. Knisley & S. Meyerhoff, *AIDS & Sports*, SPORTING NEWS, November 9, 1992, at 12.

47. *Id.* at para 6.

The 1989 *Consensus Statement from Consultation on AIDS and Sports*, developed jointly by the World Health Organization and the International Federation of Sports Medicine states that '(t)here is no medical or public health justification for testing or screening for HIV infection prior to participation in sports activities. *WHO Consensus Statement*, (1989) at para 5. The Statement advocates AIDS education for athletes, recommending that skin lesions should be immediately cleansed and covered, and that bleeding players should not participate in sports until bleeding has been stopped and the wound has been cleansed, and covered or occluded. No coercive measures are envisaged; the Statement merely notes that '[p]ersons who know they are HIV infected should seek medical counselling about further participation in sports in order to assess risks to their own health as well as the theoretically possible risk of transmission of HIV to others.' *Id.*

48. This term derives from 'sin-bin' which describes the temporary removal of a player

must have stopped, and all contaminated clothing and equipment must be replaced before an injured player resumes participation in the game. The *Policy Statement on Infectious Disease Transmission in Sport* made by the New Zealand Federation of Sports Medicine is in similar terms. Other national and international sports federations have also developed policies.⁴⁹

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

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

Despite these responses from peak sports bodies, it is uncertain that all Australian sports bodies will adopt an infection control policy based solely upon the elimination of 'blood contact' between players. There have, in the past, been some indications that HIV-/HBV/HCV testing may become an eligibility criterion for participation in some elite sports, and that HIV positivity may be grounds for deregistration.⁵⁰

Mention has been made already of a widely reported incident in Tasmania where the North-East Football Union withdrew the registration of a player who had tested HIV positive.⁵¹ In 1992, players for the St. Kilda and Richmond clubs in the AFL were required to be inoculated for HBV, and tested for HIV antibodies under an

from participation for a misdemeanor.

49. For example, the International Basketball Federation (FIBA) Regulations on the Prevention of AIDS adopted Dec. 21, 1991; see A. Cohen, *A Bloodless Victory: Fear of AIDS Prompts Stricter Guidelines*, THE SPORTS LAWYER, Jan/Feb 1994, at 8.

50. See, e.g., *League AIDS Tests May be Compulsory*, THE AUSTRALIAN, Feb. 5, 1992, at 23.

51. See *supra* note 6.

insurance agreement covering all players in each club.⁵² Players are not, however, tested at regular intervals. Some sports, including the AFL and the New South Wales Rugby League (NSWRL),⁵³ have introduced 'blood-bin' and infection control policies similar to the ASMF Infectious Diseases Policy mentioned above. In the NSWRL, referees are authorized to, and responsible for ordering bleeding players into the 'blood bin'. Until recently, AFL umpires did not have this right, which was exercised by the team medical officer.⁵⁴ AFL medical officers, and, vicariously, clubs ran the risk that, by virtue of being on the sideline, they would not be aware when an injury occurred which caused bleeding, although television and communication with trainers reduced this possibility. One AFL medical officer warned privately that doctors who are subject to pressures from coaches and team management may not be as diligent in ensuring that bleeding players are removed from the field.⁵⁵

IV. ASCERTAINING THE EXISTENCE OF HIV/HEPATITIS INFECTION IN SPORTS: LEGAL CONSTRAINTS

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

52. *AFL Acts on AIDS*, THE SUNDAY AGE, Feb. 2, 1992.

53. The NSWRL is the national professional competition for rugby league. From 1995 it will be called the Australian Rugby League.

54. *AFL Under Fire Over New Law on Bleeding Players*, AGE Aug. 4, 1994, at 30.; *HIV Rules Require More Players: AFL Coach*, AUSTRALIAN, Aug. 8, 1994, at 3, (commenting on controversial new AFL Rule 9B relating to bleeding players and blood-borne infections).

55. For discussion of the legal context and consequences of distorted clinical judgments by team doctors under pressure from sports administrators, or subject to 'fan syndrome', see H. Opie, *The Team/Doctor/Athlete Legal Relationship*, 2 SPORTS TRAINING, MEDICINE AND REHABILITATION 287 (1991).

administered by the organization are HIV/hepatitis infected?

Of course, HIV/hepatitis testing, even if perfectly legal, has its limitations. Taken alone, HIV antibody testing is a dangerously illusory solution to the risk of HIV transmission in sports.⁵⁶ Persons infected with HIV typically do not show antibodies to the virus for 6 weeks to 3 months.⁵⁷ In view of this 'window period', it is important that a negative HIV test result should not be regarded as a substitute for infection control standards such as those advocated in the ASMF Policy. A similar window period may occur following HBV infection, prior to the production of HBsAg (Australia antigen), and later HBV 'e' antigen (HBeAg) in the carrier's blood. The incubation period for HCV is highly variable, ranging from 2 to 26 weeks, with a mean period of 22 weeks.⁵⁸ Since screening tests only reflect the situation prior to the 'window period', they provide no insurance against future transmission (and future 'window periods') if a person continues to engage in high risk activities off-field.

A. *The Legality of HIV/Hepatitis Testing in Sports*

1. Legal Basis for Testing

Medical testing is an ordinary part of participation in sports at an elite level, although not at a community level in Australia. Random and pre-competition testing for performance-enhancing drugs in sports is already carried out in many sports played at the elite level, prompting some to argue that 'if players can be tested for steroids, why not HIV?'⁵⁹ Consent to medical examination and drug-testing is provided for in entry forms, scholarship and representative team membership agreements,⁶⁰ and in contracts between professional athletes and their clubs. Such mechanisms could arguably be extended by clubs or competition organizers wishing athletes to undergo HIV/hepatitis testing either as a precondition to participation in an event (for example, a boxing match),

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

57. N. Crofts, *Patterns of Infection*, AIDS IN AUSTRALIA 24, 26 (1992). Some studies have shown that in rare cases, the 'window period' may last as long as 3 years; see D. T. Imagawa, M. H. Lee, S. M. Wolinsky, et al., *Human Immunodeficiency Virus Type 1 Infection in Homosexual Men who Remain Seronegative for Prolonged Periods*, 320 THE NEW ENGLAND JOURNAL OF MEDICINE 1458 (1989).

58. K. Watson, *Hepatitis C Infection in Australia*, MODERN MEDICINE OF AUSTRALIA 18, 22 (July 1991).

59. J. Niall, *AIDS in Sport*, 16S INSIDE SPORT 14, 21 (Apr. 1993).

60. H. Opie, *Legal Regimes for the Control of Performance-Enhancing Drugs in Sport*, 12 ADELAIDE LAW REVIEW 332, 348 (1990).

or to membership of a club or entry into a competition.

In some cases, HIV/hepatitis screening might arguably be authorized under existing contractual provisions. The standard playing contract of the Victorian Country Football League, for example, requires players to 'do everything reasonably necessary to obtain and maintain the best possible physical condition . . . and to submit from time to time and as and when required by the Club to a complete and thorough medical fitness test and examination'.⁶¹

Some combat sports, notably martial arts, wrestling and boxing, are regulated by legislation. The medical examination of participants in contests is mandated by legislation as part of a wider policy to ensure that contestants are not injured. In Victoria, for example, participants in professional martial arts contests and amateur martial arts (full contact) contests, as well as professional boxers, must be registered; must provide certificates of fitness prior to registration; and must submit to medical examination both before and after contests.⁶² Current regulations require professional boxers to disclose whether they have or have had hepatitis prior to registration,⁶³ and martial arts contestants must do the same.⁶⁴ It is possible that regulations could be amended to require competitors to produce negative HIV/HBV/HCV reports as a pre-requisite to competition or registration.⁶⁵ Direct imposition of requirements by the legislature would avoid some of the possible legal obstacles to mandatory HIV/HBV/HCV testing which arise under the common law.

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

61. Cl. 2.7. The standard playing contract which until recently has governed all AFL players requires players to "obey all reasonable directions of the Senior Coach, Chief Executive, General Manager and Board of Directors of the Club" and to "do everything reasonably necessary to obtain and maintain the best possible physical condition . . ." *Id.* at Cls. 2.3, 2.10. Players seeking selection by the Australian Basketball Federation in the Australian national representative team must "disclose forthwith to the Team Manager, the Team Medical Officer any injury or illness that might prejudice my proper participation in any events." 1989-1992 Team Membership Agreement, Cl. 2.6.

62. MARTIAL ARTS CONTROL ACT 1986 (Vic) §§ 8, 10; PROFESSIONAL BOXING CONTROL ACT 1985 (Vic) §§ 10, 12; similarly, BOXING AND WRESTLING CONTROL ACT 1986 (NSW) §§ 8, 15, 49-51; BOXING CONTROL ACT 1987 (WA) §§ 18-20, 48-51; BOXING CONTROL ACT 1993 (ACT) §§ 14-16.

63. PROFESSIONAL BOXING CONTROL REGULATIONS 1986 (Vic) reg 71.

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

65. South Australian boxers are currently required to prove that they do not have HIV before being allowed to compete professionally. See *HIV Check in Boxing*, THE AGE 13 (May 1993).

quite independently of any contract.

2. Consent

Consent to diagnostic testing is also a requirement imposed by the common law. Regardless of whether an athlete has entered into a contractual relationship with a sports organization, the administration of HIV/hepatitis tests involve medical procedures which require the athlete's consent. The withdrawal of a blood sample *without consent*, or in the face of an athlete's objections, may constitute a criminal or tortious assault, regardless of whether the athlete's refusal to undergo testing constitutes a breach of contract, team agreement or other rule.⁶⁶

However, the real issue which arises in this context is whether a general acquiescence to medical treatment and examination, or to the withdrawal of a blood sample, includes consent to HIV/hepatitis testing, or whether in the absence of specific consent to such a test, a doctor (and vicariously, his or her employer), will be liable in negligence for breach of the duty to provide information and to obtain adequate consent to medical procedures.⁶⁷ An AFL player, for example, may have a contractual obligation to obey the directions of his coach, and may willingly put out his arm for a 'blood test' as part of a medical examination carried out by the team doctor, but will this, without more, be a sufficient consent if an HIV test is subsequently performed? Current academic opinion appears to assume not.⁶⁸

The general principle is that every athlete has the right 'to decide for himself or herself whether or not to submit to the medical treatment proposed',⁶⁹ which in turn requires adequate disclo-

66. H. Opie, *Legal Regimes for the Control of Performance-Enhancing Drugs in Sport*, 12 ADELAIDE LAW REVIEW 332, 348 (1990).

67. For a more detailed discussion, see R. S. Magnusson *Specific Consent, Fiduciary Standards and the Use of Human Tissue for Sensitive Diagnostic Tests and in Research*, 2 JOURNAL OF LAW AND MEDICINE (1994).

68. See *Human Immunodeficiency Virus (HIV) Antibody Testing*, 295 BRITISH MEDICAL JOURNAL 911 (1987); *HIV Antibody Testing: Summary of BMA Guidance*, 295 BRITISH MEDICAL JOURNAL 940 (1987); J. Hamblin, *Health Care: Rights and Responsibilities*, LAW SOCIETY JOURNAL 66, 67 (May 1990); W. T. West, *Assault and Battery - Testing for 'AIDS*, JUSTICE OF THE PEACE, Dec. 22, 1990, at 812; M. S. Swartz, *AIDS Testing and Informed Consent*, 13 JOURNAL OF HEALTH POLITICS, POLICY AND LAW 607 (1988); J. GODWIN, J. HAMBLIN, D. PATTERSON, AND D. BUCHANAN, AUSTRALIAN HIV/AIDS LEGAL GUIDE 181-82 (2nd ed 1993); J. Keown, *The Ashes of AIDS and the Phoenix of Informed Consent*, 52 MODERN LAW REVIEW 790 (1989). It is quite unlikely that the doctor would be liable for battery, where the patient has been informed in broad terms of the nature of the procedure; i.e. has consented to the withdrawal of blood: see *Chatterton v. Gerson*, 3 WLR 1003, 1013 (1980); *Rogers v. Whitaker*, 175 CLR 479, 490 (1992).

69. *Rogers v. Whitaker*, 175 CLR 479, 486 (1992).

sure of the nature of the procedure and of *material* risks.⁷⁰

However, this argument fails to distinguish between risks inherent in a medical procedure, and the risk that a person may suffer harm on being informed of the results of a diagnostic procedure, or as a result of being an HIV positive person. In *Rogers v. Whitaker*, the patient knew and had consented to the medical procedure performed, although it was alleged that material risks associated with the procedure were not disclosed. This case is quite different from the situation where a doctor fails to inform a patient that a particular diagnostic test will be performed on a blood sample drawn from the patient without incident, which reveals the fact that a patient is already HIV infected. The athlete may not have wanted to be tested for HIV (had he or she been consulted), but that does not mean the doctor will be liable for the medical, financial and emotional consequences the athlete suffers as a result of being *diagnosed* as HIV positive.⁷¹ The argument fails at the level of causation. For a start, an HIV test result would be confidential in the hands of the doctor; the doctor could not be liable if the athlete 'went public', thereby losing employment or sponsorships. Nor could the doctor be liable for the medical consequences of the patient's diagnosis merely for bringing them to the patient's knowledge; indeed, one could argue that the patient's health would benefit from early HIV diagnosis. It is conceivable, however, that a doctor could be liable for a nervous shock reaction suffered by the patient, in extremely rare circumstances where the failure to obtain specific consent and to counsel the patient were, without more, responsible for a 'nervous shock' reaction amounting to an enduring physical or psychogenic illness, over and above the normal distress of being diagnosed as HIV positive.⁷²

70. *Id.* at 490. The High Court of Australia in *Rogers* held that a doctor's duty to inform the patient of material risks will be discharged by disclosure of such risks as a reasonable person in the patient's position would be likely to attach significance to, if warned of them. *Id.* Assuming that an athlete would wish to take the potentially enormous medical, psychological, social and financial consequences of a positive HIV test result into account as factors in deciding whether to undergo the test, it is tempting to argue that HIV testing without specific consent and counselling would be in breach of the doctor's duty to disclose material risks. *Id.*

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

72. Except as provided under the nervous shock cases, there is no action in Anglo-Australian law for negligently caused psychiatric or other emotional injury suffered alone: *Alcock v. Chief Constable of South Yorkshire*, 1 AC 310, 400-1 (1992). Courts have generally only imposed liability for nervous shock where the plaintiff's injury was caused by apprehended physical injury (i.e. violent impact) to the plaintiff or third parties. It is less clear whether the doctrine applies in the information disclosure context; see however: *Owens v. Liverpool Corporation*, 1 KB 394, 400 (1939) (holding principles not limited to cases in which appre-

It is nevertheless arguable that, at least in circumstances where the medical information revealed by a diagnostic test is sensitive, or where the reasonable patient would wish to be informed that a particular diagnostic test was being performed, the interest or right of a patient to decide his or her own medical future supports the duty to obtain specific consent. If competent adult patients have the right to refuse medical treatment, 'however unreasonable or foolish this may appear in the eyes of [their] medical advisers',⁷³ they would also seem to have the right to refuse diagnostic procedures, even if this conflicted with the doctor's view of what was in the patient's best interests. Ultimately, this raises the issue of whether patients should have the right to veto certain investigations undertaken by the doctor in diagnosing a patient.

In our view, the argument that HIV testing requires specific consent is reasonable in view of the sensitivity of HIV test results, and the disastrous consequences which their disclosure may bring for the individual concerned.⁷⁴ The appropriate legal basis for this position is not, however, negligence, but the fiduciary quality of the doctor/patient relationship, which imposes on the doctor a standard of conduct requiring undivided loyalty. Australian courts have taken a more restrictive view of what constitutes a fiduciary relationship than United States courts. The doctor/patient relationship is not among the core relationships which are presumed by law to be fiduciary in character. Outside of the core relationships, however, a fiduciary standard of conduct may nevertheless be imposed upon an ascendant party to a relationship 'as a matter of fact arising out of the specific circumstances of the relationship'.⁷⁵ In recent years

hension to human safety is involved); *Barnes v. Commonwealth*, 37 SR 511 (1937) (accepting there could be liability for negligent disclosure of information causing nervous shock).

73. *Smith v. Auckland Hospital Board*, NZLR 191, 219 (1965); *Secretary, Department of Health and Community Services v. JWB and SMB* (1992) 175 CLR 218, 309-10. The law respects this right, even if it will have fatal consequences; for example: *In re T*, 3 WLR 782 (1992).

74. *Turkington*, for example, makes the point that:

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

R. C. *Turkington*, *Confidentiality Policy for HIV-Related Information: An Analytical Framework for Sorting Out Hard and Easy Cases*' (1989) 34 VILLANOVA LAW REVIEW 871, 892 (1989).

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

courts have been more willing to regard the doctor/patient relationship as involving obligations of a fiduciary character, at least for some purposes.⁷⁶ Canadian and New Zealand courts have pointed to the fiduciary nature of the relationship as the basis for the doctor's duty of confidence.⁷⁷ The Canadian Supreme Court has also recently held that since medical records contain highly private information which 'goes to the personal integrity and autonomy of the patient', and since the doctor/patient relationship is a fiduciary one, the medical record will be held by the doctor 'on trust' for the patient, in the sense that a patient will have the right of control over the information contained in the record, including a right of access to that information.⁷⁸ However, a recent New South Wales decision does not support this view.⁷⁹

In our view, it does not unduly strain legal principle to argue that doctors owe a fiduciary duty to ensure that patients are informed of proposed *sensitive* diagnostic tests, including HIV tests, and not to act contrary to the perceived interests of patients by performing non-consensual testing.⁸⁰ On this view, therefore, clubs and sports organizations wishing to test athletes for HIV must inform them and obtain specific consent to the withdrawal of blood for this purpose.

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

76. *Hospital Products Ltd. v. United States Surgical Corporation*, 156 CLR 41, 69 (1984).

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

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

79. *Breen v. Williams* (Supreme Court of New South Wales, J. Bryson, Oct. 10, 1994, 2363 of 1994).

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

3. Mandatory HIV/Hepatitis Testing and Discrimination

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

Turning first to discrimination, the issue here is whether it is discriminatory to *require* athletes to undergo mandatory testing for infectious diseases, not whether the exclusion of infected athletes is discriminatory.⁸¹ This provision relies largely on the federal government's power to make laws with respect to enacting into domestic law various obligations which Australia has assumed under international law pertaining to human rights. It applies to any person and this would include the members of an unincorporated association operating as a sports club, an incorporated sports club whether at the community, governing body or professional level, and those individuals who control the affairs of such clubs. In addition, Section 27 of the Act provides that it is unlawful for a club⁸² or incorporated association, its committee of management and the members of the committee to discriminate on the ground of a person's disability by: (1) refusing membership or imposing terms on membership to an applicant; and, *inter alia*, (2) imposing terms and conditions, denying access to facilities or benefits or subjecting to detriment a member of the club or association. A 'disability', for the purposes of the Act, includes the presence in the body of organisms causing or capable of causing disease or illness.⁸³ Alterna-

81. A number of exceptions are created by § 28(3) mainly relating to a person's ability to perform the actions required of the sporting activity. These are not relevant for present purposes. The Australian DISABILITY DISCRIMINATION ACT 1992 (Cth) § 28(1) provides that: "[i]t is unlawful for a person to discriminate against another person on the ground of the other person's disability or a disability of any of the other person's associates by excluding that other person from a sporting activity." *Id.*

82. A "club", for the purposes of the Act, includes an association, whether incorporated or unincorporated, which exists for sporting or athletic purposes.

83. DISABILITY DISCRIMINATION ACT 1992 (Cth) § 4(1). A "disability" is also defined to include a presently existing or previously existing disability, and a disability which may exist in the future, or is imputed to a person. Symptomless, or symptomatic infections, including HIV and HBV/HCV infection, therefore, are 'disabilities' which attract the protection of §§ 27-8. Under § 48 of the Act, however, it is lawful to discriminate against a person on the ground of their having an infectious disease where the discrimination is 'reasonably necessary to

tively, if a person is excluded from an event, club or competition because they have refused to comply with a condition that they undergo HIV testing, it is arguable that such an exclusion is an act of discrimination on the basis that its effect is to impute a disability to the person refusing to undergo the test.

A club or sports organization, may, of course, seek to show that there are no adverse consequences which follow from being diagnosed with HIV/hepatitis, and that testing is only carried out so that athletes can be made aware of their health status and take necessary precautions, or so that the sports organization can take necessary precautions for infection control. Under these circumstances, it is likely that a mandatory testing requirement would not breach §§ 27-8. Furthermore, even if a mandatory testing program, like exclusion from a sport on the basis that an athlete is HIV/HB-V/HCV infected, is literally discriminatory, it will not be unlawful if the risk of transmission of HIV/HBV/HCV in sports is such that discrimination is 'reasonably necessary to protect public health'. This exception is discussed below.⁸⁴

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

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

The more difficult issue concerns the relationship between selective testing, the public health exception, and other discrimination

protect public health'. *Id.*

In so far as a sports organization, or persons having effective control of it, *require* athletes to be tested for an infectious disease such as HIV/hepatitis in circumstances where being diagnosed with HIV/hepatitis will result in their exclusion from a club, event or competition, it is arguable that such testing is discriminatory, since it is a necessary precursor to refusing membership or imposing some detriment; that is, to the performance of an unlawful act - under § 27 or § 28. In that sense, compulsory testing is an integral part of an act of discrimination. In some cases, legislation prohibits requests for information which will be used as a basis for discriminating against a person, or information which a person without an impairment would not be required to provide. DISABILITY DISCRIMINATION ACT 1992 (Cth) § 30; EQUAL OPPORTUNITY ACT 1984 (WA) § 66O.

84. *See id.* at Section 5.(c).

statutes. If, as we believe, the exclusion of infected athletes may, in some sports, be justified as 'reasonably necessary to protect public health',⁸⁵ it follows that requiring athletes to undergo testing for HIV/hepatitis would also be justified in these sports. A potential conflict may arise, however, where a club or sports organization wishes to limit testing to Aborigines or homosexuals, perhaps in view of the cost of testing, and the higher probability that Aborigines or homosexuals will be infected. It is likely that such practices would be in breach of legislation protecting Aborigines⁸⁶ and homosexuals⁸⁷ from discrimination. While exclusion on the basis of the risk to health of other athletes may be justified (regardless of whether the infected athlete is an Aborigine or a homosexual), legislation may nevertheless protect such groups from being 'picked on' by virtue of their aboriginality or homosexuality, if efforts were not made to identify *all* potentially infected athletes, and thus to apply the exclusion without reference to racial origin or sexual orientation.

4. Mandatory HIV/Hepatitis Testing and Restraint of Trade

The compulsory HIV/hepatitis testing of athletes might also be challenged as being in restraint of trade,⁸⁸ provided that (1) the athlete earns an income from participation in sports, and (2) it is clear that the athlete will be denied entry into an event or club or

85. *Id.*

86. The RACIAL DISCRIMINATION ACT 1975 (Cth) § 9 prohibits discrimination on the grounds of race or ethnic origin.

87. Discrimination on the ground of sexual orientation is prohibited in some jurisdictions: ANTI-DISCRIMINATION ACT § 49ZG (1977); EQUAL OPPORTUNITY ACT § 29(3) (1984); ANTI-DISCRIMINATION ACT § 7(1) (1977) (outlaws discrimination on the grounds of lawful sexual activity); DISCRIMINATION ACT § 4(1), 7(1)(b) (1991); ANTI-DISCRIMINATION ACT § 4, 19 (1992). Discrimination on the grounds of sexual orientation is not prohibited in the remaining Australian jurisdictions. At the Commonwealth level, the HUMAN RIGHTS AND EQUAL OPPORTUNITY COMMISSION ACT § 20-35 (1986), gives the Commission power to inquire into and to conciliate complaints of discrimination on the grounds of sexual preference (by virtue of HUMAN RIGHTS AND EQUAL OPPORTUNITY COMMISSION REGULATIONS REG 4(a)(ix) (1989). Tasmania is now the only Australian jurisdiction where homosexuality remains a crime (see CRIMINAL CODE ACT § 122-3 (1924), although the Human Rights (Sexual Conduct) Bill (1994) has been introduced into federal Parliament with the intention of overriding this.

88. Restraint of trade is a common law doctrine and has been the principal means used by Australian athletes to challenge rules of sport which restrict their ability to freely pursue their professional sports careers. Federal legislation in the form of the TRADE PRACTICES ACT Part IV (1974) outlaws a wide range of anti-competitive business activity. This legislation owes a substantial portion of its jurisprudential basis to United States antitrust law. However, it has had little impact on professional team sports because it does not extend to employment contracts; see further: H. Opie and G. Smith, *Professional Team Sports and Employment Law in Australia: From Individualism to Collective Labour Relations?*, 2 MARQ. SPORTS L. J. 211, 224-25 (1992). This legislation will not be considered in this paper.

competition for refusing to undergo testing. It is well established that an athlete who earns all or some of their income from engaging in sports, or who has a real potential to do so, will be within the ambit of the restraint of trade doctrine.⁸⁹

A common type of restraint of trade case brought before the courts over the past two decades has concerned some rule which restricts the athlete from freely contracting with an employer of his or her choice⁹⁰ or from entering into a rival competition.⁹¹ Examples of these rules are the transfer, zoning and draft rules in professional sports leagues. Usually, that rule will be a rule of the sport's governing body rather than of the body which is paying the athlete to participate. Furthermore, the restraint of trade doctrine will apply even if the athlete does not directly receive income from participation.⁹² For example, an athlete may not receive income from the act of participation, but derive income from other sources such as sponsorships, appearances and advertising which are dependent on the ability of the athlete to participate. This is more likely to be the case with 'amateur' athletes from sports such as track and field and swimming. Thus, compulsory HIV testing as a condition precedent to entry into a club, league, event or competition, whether a condition precedent to a contract or not, can operate as a restraint on all or any of the identified income sources.⁹³ Thus, HIV testing must be shown to be a reasonable restraint in order to have legal effect.

Reasonableness is determined having regard to the legitimate interests of the parties concerned, and the public.⁹⁴ The defendant bears the onus of showing that the restraint goes no further than is reasonably necessary to protect its legitimate interests. There is some uncertainty, however, over whether or not the reasonableness of the restraint should be determined or influenced by balancing

89. *Hughes v. Western Australian Cricket Association, Inc.*, 69 ALR 660, 700 (1986). Restraints on an athlete's ability to pursue his or her sporting trade are *prima facie* contrary to public policy and therefore void. The restraint will only be saved if it can be shown to be reasonable. *Buckley v. Tutty*, 125 CLR 353, 380 (1971).

90. *See, e.g., Adamson v. New South Wales Rugby League Ltd.*, 31 FCR 242 (1991), *Adamson v. West Perth Football Club Inc.*, 27 ALR 475, (1979); *Buckley v. Tutty*, 125 CLR 353 (1971); *Hall v. Victorian Football League VR 64* (1984); *Kemp v. New Zealand Rugby Football League Inc.*, 3 NZLR 463 (1989).

91. *See, e.g., McCarthy v. Australian Rough Riders Association Inc.*, ATPR ¶40-836 (1988).

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

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

94. *Nordenfelt v. Maxim Nordenfelt Guns and Ammunition Co. Ltd.*, AC 535, 565 (1894).

the strength of the defendant's interests against the effects which the restraint will have on the person restrained (the plaintiff), and on other third parties.⁹⁵

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

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

95. See *Adamson v. New South Wales Rugby League Ltd.*, 31 FCR 242, 266 (1991); see Humphreys, *Sport, Restraint of Trade and the Australian Courts: Adamson v. New South Wales Rugby League Ltd.*, 15 SYDNEY LAW REVIEW 92, 94-97 (1993).

5. Mandatory HIV/Hepatitis Testing and Breach of Contract

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

6. An Obligation to Conduct Mandatory HIV/Hepatitis Testing?

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

This could arise from a general duty of care under the tort of negligence owed by a sports organization to people in its teams or league, or using its facilities. Furthermore, the obligation to test may arise under the implied contractual duty of care where the organization has employees. '[T]his duty will also usually be enforceable as a wider statutory duty under occupational health and safety legislation'⁹⁶ such as Section 21 of the Occupational Health and Safety Act 1985 (Vic). These duties and their possible application will be considered under Section 6.

To complete this discussion of the legality of mandatory HIV/hepatitis testing, it should be noted that public health legislation in most Australian jurisdictions authorizes the compulsory medical examination of individuals thought to be HIV/hepatitis infected as a first step under legislative schemes providing for isolation and quarantine of persons whose infection or behavior creates a risk to

96. Opie and Smith, *supra* note 88, at 211, 231.

public health.⁹⁷ Health Department guidelines or protocols in some States provide for the staged exercise of these powers where an HIV infected person continues to share injecting equipment, or to engage in unprotected penetrative anal or vaginal sex.⁹⁸ The possible application of these powers to HIV positive athletes engaging in combat or contact sports does not appear to have arisen and is highly unlikely while following infection control and 'blood-bin' procedures.

B. Finding Out About an Athlete's Status: Confidentiality and the Duty to Warn

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

Diagnosis of HIV/hepatitis is by way of blood testing carried out in laboratories, with results being returned to the doctor who first requested the test. What are the legal considerations relevant to dissemination of an athlete's HIV/hepatitis status? We will commence with an examination of relevant legislative controls before turning to an athlete's consent either express, or implied under the 'athlete/team/doctor' relationship. Finally, there are the issues of whether the public interest exception to the doctor's duty of confidentiality authorizes disclosure and whether there may be legal

97. PUBLIC HEALTH ACT § 22-3 (1991); HEALTH ACT § 121 (1958); PUBLIC AND ENVIRONMENTAL HEALTH ACT § 31-2 (1987); HEALTH ACT § 251(5) (1911); HEALTH ACT § 36 (1937); HIV/AIDS PREVENTIVE MEASURES ACT § 10(3) (1993); NOTIFIABLE DISEASES ACT § 11, 14 (1981).

98. In August 1989 a Sydney prostitute known as "Charlene" was detained at the Prince Henry Hospital under § 32A of the then PUBLIC HEALTH ACT (1902); *See Govt Orders AIDS Prostitute Held in Hospital*, THE SYDNEY MORNING HERALD, August 1, 1989. In March 1991 in Melbourne, police charged an HIV infected trans-sexual prostitute with "conduct recklessly endangering life", after the Health Department refused to exercise its powers under the Health Act § 121-2 (1958); *See Prostitute with AIDS Charged by Police*, THE AGE, March 26, 1991. A second prostitute was subsequently charged. Both charges were eventually dropped for lack of evidence. *See also Detectives Seek Man in Resort HIV Scare*, THE AUSTRALIAN, Jan. 20, 1994, at 3; *HIV Man Detained as a Public Risk*, AGE, Sept. 17, 1994, at 1.

liability for not having made disclosure in the event that a third party contracts the infectious disease.

1. Legislative Regulation of Disclosure of Medical Information

Legislation in some jurisdictions regulates (1) the disclosure of all medical information acquired by particular categories of health professionals, and (2) the disclosure of certain kinds of medical information, most notably, in this context, HIV information. The legislation is significant in that, in some cases, it excludes the 'public interest' exception which exists under the common law, as discussed below. In some jurisdictions, it would also appear to preclude the 'team doctor' justification for disclosure of HIV information, discussed in the following section. Legislation in New South Wales, Victoria, South Australia and Queensland imposes duties of non-disclosure with respect to medical information acquired during the course of employment of health professionals employed in public hospitals and other government funded facilities.⁹⁹ Where an athlete attends a private practitioner, however, none of these statutory restrictions, or exceptions, would be relevant.

Overlapping with the abovementioned provisions, but not limited to public sector health professionals, is legislation which specifically regulates the disclosure of HIV information.¹⁰⁰ In Tasmania, the *HIV/AIDS Preventive Measures Act 1993* imposes a duty of non-disclosure with respect to HIV test results, HIV antibody status, and information relating to the sexual behavior and drug use of a test subject.¹⁰¹ The prohibition is subject to several enumerated exceptions, including consent, disclosure to other medical professionals involved in treating or counseling the patient, and disclosure otherwise authorized or required under the Act. In New South Wales, the *Public Health Act 1991* imposes upon persons who, in the course of providing a service, learn that a person has HIV/AIDS, a duty to 'take all reasonable steps to prevent disclosure of the information to another person'.¹⁰² Arguably, this provision would extend to doctors drawing a blood sample, requesting an HIV test and receiving the results. The statutory exceptions authorize, *inter*

99. HEALTH SERVICES ACT § 141 (1988). This law, applies, *inter alia*, to employees of "relevant health services," defined as public and private hospitals, nursing homes, community health services and day care centres. In Victoria, the statutory duty is lifted where the Minister certifies disclosure to be in the public interest, and in Queensland, where disclosure is required by operation of law. See HEALTH ADMINISTRATION ACT § 22 (1982); SOUTH AUSTRALIAN HEALTH COMMISSION ACT § 64 (1976); HEALTH SERVICES ACT § 5.1 (1991).

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

101. HIV/AIDS PREVENTIVE MEASURES ACT §19(1) (1993).

102. PUBLIC HEALTH ACT § 17(2) (1991).

alia, disclosure with consent, and disclosure to the Director-General if the person's behavior places public health at risk.¹⁰³

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

Finally, in Victoria, service providers acquiring knowledge that a person has HIV are required to 'take all reasonable steps to develop and implement systems to protect the privacy of that person.'¹⁰⁴ In contrast to the above, there is nothing to suggest that this provision excludes common law exceptions to confidentiality.

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

2. Express Consent: Disclosure of Medical Information Pursuant to Contract

Contractual arrangements may authorize medical practitioners to disclose medical information to members of a governing body.¹⁰⁵ In addition, a contract may require an athlete to personally disclose any relevant medical information which may impact upon his or her participation and performance to a club or governing body.¹⁰⁶ It is certainly arguable that a symptomless HIV infection, in so far as it could become symptomatic and affect the player's health during the course of the contract, could be included within the terms of such a warranty.

103. PUBLIC HEALTH ACT § 17(3)(e) (1991).

104. HEALTH ACT § 128 (1958).

105. See 1992 AUSTRALIAN OLYMPIC TEAM MEMBERSHIP AGREEMENT, Cl. 4.1, [hereinafter Cl.]. Under § 4.1, athletes authorised "any medical practitioner, sports scientist or therapist whom I have consulted during the 12 months preceding the commencement of the Olympic Games to provide details of any illness and/or injury which I have sustained or may sustain or of any pre-existing medical condition to the Chief Medical Officer of the Team . . ." *Id.* Furthermore, athletes authorized the Chief Medical Officer to disclose any information thereby obtained to the Secretary-General of the Australian Olympic Committee, and to the Chief Executive Officer of the athlete's national federation. *Id.* at Cl. 4.2.

106. The Australian Cricket Board's Player contract, for example, includes a warranty by the player that "at the date upon which he signs this Agreement he is not suffering and has not suffered from any illness or injury or other ailment of which he is aware which may render him incapable of performing his obligations hereunder except any injury illness or other ailment of which the Selectors are aware." Cl. 5.2.3.

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

3. "Implied" Consent: The Athlete/Team/Doctor Relationship

It is important to distinguish between the bipartite relationship which arises when an athlete, of his or her own volition, consults a doctor in a private capacity, and the tripartite relationship which arises when an athlete consults a doctor engaged by a team to provide medical services for its athletes. In the latter case, the 'team doctor', like a company-employed doctor, will have legal responsibilities toward the team (or company), as well as to the athlete/patient.¹⁰⁷ These responsibilities may justify disclosures to third parties which would otherwise constitute a breach of confidentiality if made by an ordinary private practitioner.¹⁰⁸

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

107. See H. Opie, *The Team/Doctor/Athlete Legal Relationship*, 2 *SPORTS TRAINING, MEDICINE and REHABILITATION* 287, 297 (1991).

108. *W. v. Egde*, 1 Ch 359 (1990). For example, L.J. Bingham stated:

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

Id. at 419.

mation such as sexual orientation or sexual practices, which a club doctor may have acquired in the process of counseling an athlete, and which is not immediately relevant to the athlete's fitness.

Team or club management, in so far as they acquire confidential medical information relating to an athlete, will have constructive if not actual notice of its confidentiality, and will thus owe a duty of confidentiality with respect to it.¹⁰⁹ They will not be at liberty to brief the media, or to discuss it over dinner with friends, without the athlete's consent. The fact that information is interesting to the public does not automatically create an exception to the duty of confidentiality.¹¹⁰ Unless the athlete contracts the right away, he or she would, on established principles, be able to obtain an injunction preventing the disclosure of information subject to a duty of confidentiality. It is not difficult to imagine a situation where information about 'athletes with AIDS' is leaked to the media. In an appropriate case, even 'innocent' third party recipients, such as newspapers may be restrained by injunction from publishing information once they receive notice that it has been acquired in breach of a duty of confidentiality.¹¹¹

A 'team doctor' who diagnoses an athlete with HIV/hepatitis may come under intense pressure not to report this to club management. This raises the whole question of the legal basis of the tripartite confidential relationship between athlete, doctor and team. If the athlete is regarded as *impliedly consenting* to disclosure to club officials, it is arguable that such consent could be expressly withdrawn, since consent is 'an expression of the autonomy of the confider'.¹¹² However, it makes more sense to regard the athlete, on consenting to diagnostic tests under the supervision of a team doctor, as being estopped from later exercising any inconsistent right to prevent disclosure of such *relevant* information as the tripartite nature of the relationship requires. A similar rationale would apply to patients who enter hospital and, by virtue of using those structures or services, impliedly consent to disclosure of medi-

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

110. See *infra* Section V.

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

112. C. Thomson, *Records, Research and Access: What Interests Should Outweigh Privacy and Confidentiality? Some Australian Answers*, 1 JOURNAL OF LAW AND MEDICINE, 95, 96 (1993).

cal information between professionals on a need-to-know basis, and to reasonable medical records procedures.¹¹³

4. The 'Public Interest' Exception to the Duty of Confidentiality

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

The argument that disclosure is or was justified in the public interest has, in practice, been made in defense to applications for injunctions or other remedies for breach of confidentiality. The scope of the defense is far from clear. At its narrowest, the 'defense' has been regarded by some judges simply as an expression of the doctrine that courts will not grant equitable remedies to enforce the legal rights of iniquitous plaintiffs who do not come to equity with clean hands.¹¹⁴ This view represents one interpretation of Wood V-C's remarks in *Gartside v Outram*,¹¹⁵ the case from which the defense originates, although it ignores subsequent developments.

In England, the public interest defense has developed as an increasingly explicit process of balancing a widening variety of 'public interests'. The underlying rationale is that although the public interest usually favors the enforcement of duties of confidentiality,¹¹⁶ such protection cannot be absolute, since there are opposing public interests favoring the free circulation of information which may sometimes outweigh the interest in confidentiality.¹¹⁷ The cases have clearly undermined the 'clean hands' view by recognizing, and balancing, successive categories of public interest in

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

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

115. 26 LJ Ch 113, 114 (1856).

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

117. See *Attorney General v. Guardian Newspapers Ltd. (No. 2)*, 1 AC 109, 282 (1990).

revealing information, in circumstances where the confider may not have acted unlawfully nor been guilty of any misconduct or 'iniquity'.¹¹⁸ Led by Lord Denning, courts have stated that the public interest exception extends to crimes, frauds and misdeeds,¹¹⁹ or, indeed, wherever there is 'just cause or excuse for breaking confidentiality'.¹²⁰

The 'just cause' approach has led courts to look increasingly at the consequences of disclosure. The cases suggest that the public interest in public health and safety is an established category which may justify disclosure of confidential information.¹²¹ Intellectually, the 'just cause' approach is useful, since it requires courts to articulate the various factors justifying the protection or non-protection of confidences in each case. The process has, however, over-extended itself in some English cases, which have dispensed with any control device based upon the *kind* or *category* of countervailing public interest put forward, and simply regarded the whole process as requiring a balancing of the public interest in enforcing confidentiality against whatever public interests are served by disclosure. Thus, for example, it has been suggested that there is a public interest, sufficient to justify disclosure of confidential information, in 'knowing the truth' about the private lives of a pop group.¹²² The 'unrestricted balancing' approach appears to have gained some support in England,¹²³ although it has faced a cool reception in Australia.¹²⁴ There is strong support for the view that duties of confidentiality cannot be cast aside merely because confidential information is interesting to the public.¹²⁵

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

119. *Initial Services Ltd. v. Putterill*, 1 QB 396, 405 (1968).

120. *Fraser v. Evans*, 1 QB 349, 362 (1969).

121. See *Hubbard v. Vosper*, 2 QB 84 (1972); *W. v. Egddell*, 1 Ch 359 (1990)

122. *Woodward v. Hutchins*, 1 WLR 760, 764 (1977).

123. *Attorney General (UK) v. Guardian Newspapers Ltd. (No. 2)*, 1 AC 109, 268-9 (1990); *Lion Lab. Ltd. v. Evans*, 1 QB 526, 539 (1985); *W. v. Egddell*, 1 Ch 359, 389, 390, 419, 420 (1990); *Attorney General v. Jonathan Cape Ltd.*, 1 QB 752, 765 (1976).

124. *Castrol Australia Party Ltd. v. Emtech Associates Party Ltd.*, 51 FLR 184, 214-5 (1980); *David Syme & Co. Ltd. v. General Motors-Holden's Ltd.*, 2 NSWLR 294, 298-9, 306; *Corrs Pavey Whiting & Byrne v. Collector of Customs (Vic)*, 14 FCR 434, 451 (1987); *Kelly v. Hawkesbury Two Party Ltd.*, (No. 3) (unreported, Supreme Court of New South Wales, November 26, 1987, Young J.); *Attorney General (UK) v. Heinemann Publishers Australia Party Ltd.*, 8 NSWLR 341, 380 (1987); *Bacich v. Australian Broadcasting Corporation*, 29 NSWLR 1, 16 (1992).

125. *British Steel Corp. v. Granada Television Ltd.*, AC 1096, 1113-14, 1168, 1175, 1189 (1981); *Lion Lab. Ltd. v. Evans*, 1 QB 526, 537, 553 (1985); *Attorney General (UK) v. Hein-*

In a number of cases, courts have either held, or stated in *dicta*, that the public interest in preventing violent physical injuries to members of the public may override the doctor's legal duty of confidentiality in appropriate circumstances.¹²⁶ English¹²⁷ and Australian¹²⁸ *dicta* support the view that the public interest defense extends to 'matters medically dangerous to the public'. This subcategory arose from the 'scientology cases',¹²⁹ which concerned information relating to practices alleged to be dangerous to mental health, although no great leap of principle is required to recognize a general public interest in *preventing physical harm to third parties*, whether from violence, catastrophe or disease. The public interest in preventing disease transmission is reflected in statutory reporting requirements for infectious diseases. It is likely, therefore, that in determining the limits of the doctor's duty of confidentiality within the doctor/athlete relationship, Australian courts would recognize a public interest in preventing the transmission of an infectious disease and balance this interest, either explicitly or implicitly, against the public interest in protecting confidentiality. Notwithstanding that confidentiality may be seen as a private or personal interest, it is clear that courts regard the interest in maintaining confidentiality as being a public interest for the purposes of the public interest exception.¹³⁰

The public interest in preserving doctor/patient confidentiality is critical in cases where a patient suffers from a stigmatized, infectious disease such as HIV. In addition to the general public interest in nurturing intrinsically confidential relationships such as the doctor/patient relationship, courts have recognized the *public health interest* in protecting doctor/patient confidentiality in cases where a

emann Publishers Australia Party Ltd., 10 NSWLR 86, 167 (1987); Attorney General for the United Kingdom v. Wellington Newspapers Ltd., 1 NZLR 129, 178 (1988); David Syme & Co. Ltd. v. General Motors-Holden's Ltd., 2 NSWLR 294, 305, 310 (1984); G v. Day 1 NSWLR, 24, 29 (1982); X v. Y 2 All ER 648, 658 (1988).

126. See, e.g., W. v. Egdell, 1 Ch 359 (1990); R. v. Crozier, 12 Cr App R(S) 206 (1990); Duncan v. Medical Disciplinary Comm., 1 NZLR 513, 521 (1986); Furniss v. Fitchett, NZLR 396, 405-6 (1958); Halls v. Mitchell, SCR 125, 136 (1928); Schering Chemicals Ltd. v. Falkman Ltd., 1 QB 1, 27 (1982).

127. Beloff v. Pressdram Ltd., 1 All ER 241, 260 (1973).

128. Castrol Australia Party Ltd. v. Emtech Assoc. Party Ltd., 51 FLR 184, 213-4 (1980); David Syme & Co. Ltd. v. General Motors-Holden's Ltd., 2 NSWLR 294, 298 (1984).

129. Hubbard v. Vosper, 2 QB 84 (1972); Church of Scientology of California v. Kaufman, RPC 635 (1973).

130. W. v. Egdell, 1 Ch 359, 415 (1990).

patient suffers from physical or mental disease.¹³¹ In *X. v Y.*,¹³² the leading AIDS confidentiality case, Justice Rose stated that the preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future individual patients "will not come forward if doctors are going to squeal on them."¹³³ Encouraging persons with, or at risk of HIV/HBV/HCV to come forward for testing, treatment and education is an integral part of the public interest in treating disease and improving health.

Balanced against this will be the public interest in preventing physical injury, in this case by preventing disease transmission to third parties. By far the highest risk of transmission will be to the athlete's sexual partners.¹³⁴ The legality of a doctor's disclosure to the unsuspecting partner of an HIV infected patient has been a topic of considerable interest, uncertainty and disagreement, both among lawyers,¹³⁵ and doctors.¹³⁶ The Legal Working Party of the Intergovernmental Committee on AIDS has recommended that professional care-givers should be protected by legislation from actions for breach of confidentiality, and for breach of duty of care for *failure* to warn a third party, when acting in accordance with partner notification protocols containing specific criteria.¹³⁷

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

132. 2 All ER 648 (1988).

133. *Id.* at 653.

134. In this context, one should note that the HIV/AIDS PREVENTIVE MEASURES ACT 1993 (Tas) § 20(7) authorizes disclosure to the sexual contacts of an HIV infected person, if the infected person continues to act recklessly.

135. Prominent contributions include: M. Neave, *AIDS - Confidentiality and the Duty to Warn*, 9 UNIVERSITY OF TASMANIA LAW REVIEW 1 (1987); R. Paterson, *AIDS, HIV Testing, and Medical Confidentiality*, 7 OTAGO LAW REVIEW 379 (1991); R. O'Dair, *Liability in Tort for the Transmission of AIDS: Some Lessons from Afar and the Prospects for the Future*, CURRENT LEGAL PROBLEMS 219, 232-41 (1990); D. G. Casswell, *Disclosure by a Physician of AIDS-Related Patient Information: An Ethical and Legal Dilemma*, 68 CANADIAN BAR REVIEW 225 (1989); see also *Bradley v. Jones*; *Bradley v. Adams*, New South Wales Court of Appeals, April 18, 1990 (Commonwealth Moot Court Judgment), COMMONWEALTH LAW BULLETIN, July 1991, at 875-9.

136. See D. I. Grove, and J. B. Mulligan, *Consent, Compulsion and Confidentiality in Relation to Testing for HIV Infection: The Views of WA Doctors*, 152 THE MEDICAL JOURNAL OF AUSTRALIA 174 (1990); R. S. Magnusson, *Privacy, Confidentiality and HIV/AIDS Health Care*, 18 THE AUSTRALIAN JOURNAL OF PUBLIC HEALTH 51, 56 (1994).

137. Intergovernmental Committee on AIDS (IGCA), Legal Working Party, *Final Report*, November 1992, 12-13 (Recommendation 2.2). These criteria are: (i) the client has refused to notify his or her partner; (ii) a real risk of HIV transmission exists; (iii) counselling to achieve behavior change has failed; (iv) advice from colleagues, or an institutional ethics committee has been sought; (v) the client has been told that notification will occur after a

The issue in the present context, however, is whether (1) disclosure by a private doctor to team or club management, or (2) disclosure by either private or team doctors to other third parties, would be justified by virtue of the risk of HIV/hepatitis transmission to other players, trainers and doctors. The strength of the public interest in disclosure, for the purposes of the public interest defense equation, will be influenced overwhelmingly by consideration of the *likelihood* of transmission, and the *seriousness* of the disease. The likelihood of transmission will depend upon the nature and frequency of blood contact in the relevant sport, whether 'blood-bin' and other infection control procedures are enforced, and whether the athlete is likely to take care in adhering to them, and in behaving responsibly. Clearly, HIV/HBV/HCV infection are all serious conditions; the physical burden of HIV, in particular, being deepened by a social perception of HIV/AIDS as abhorrent and shameful.¹³⁸

Even where the factors relevant to an assessment of competing public interests have been identified, it is nevertheless difficult to predict how courts are likely to react. The issue is similar in some ways to that which faces a physician whose patient is a surgeon infected with HIV/HBV/HCV, who is carrying out invasive procedures on patients. In the latter case, the *surgeon* may be in breach of a duty of care in not informing patients of his or her infection.¹³⁹ However, assuming that the surgeon was using universal precautions to minimize the risk of blood or fluid contact with the patient, and in view of the low risk of transmission,¹⁴⁰ it is unlikely that the public interest would justify a disclosure by the

reasonable time; and (vi) the partner should be obliged to keep the confidential information revealed during notification if the identity of the client is impossible to conceal. *Id.*

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

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

140. The Center for Disease Control in Atlanta has estimated the risk of HIV transmission from surgeon to patient as in the range of 1/40,000 and 1/400,000, and in the range of 1 in 260,000 to 2.6 million from dentist to patient. N. Daniels, *HIV-Infected Health Care Professionals: Public Threat or Public Sacrifice?*, 70 THE MILBANK QUARTERLY 3, 13 (1992). Nevertheless, the CDC has reported 20 clusters of documented transmission of HBV from health care workers to over 300 patients since 1970. *Id.* at 11. Five Florida patients have also been reported as contracting HIV from a bisexual dentist. *Dentist Kept Infection Secret, Five Infected*, THE CANBERRA TIMES, July 24, 1991, at 12.

surgeon's private *physician* to the surgeon's employers or patients.¹⁴¹ This view has been acknowledged, explicitly or implicitly, in the guidelines of some professional medical bodies.¹⁴² Similarly, it is unlikely that without an athlete's consent, a private doctor could justify disclosure of an athlete's HIV/HBV/HCV status to team officials (less still to the media), as being in the public interest. Nor, in view of the generally accepted low risk of HIV/hepatitis transmission in sports, do we believe the public interest exception would justify team doctors or team management informing other athletes of the health status of an infected athlete; less still the media.

5. Liability for Failure to Warn

Although some judges have spoken (loosely) of a *duty* to disclose confidential information in the public interest,¹⁴³ strictly, what they are identifying is a *defense* to the action for breach of confidentiality. When the defense applies, the confidante is at liberty to disclose confidential information. The defense does not require disclosure, it merely permits it.

This section concerns distinct but closely related issues. Where a confidante is at liberty to disclose confidential information, are there circumstances in which the law of negligence will impose liability for omitting to do so? Furthermore, could a conflict occur between the law of confidential information and the law of negligence such that a confidante would not be at liberty to disclose, but at the same time be liable in negligence to an injured third party (plaintiff) for not having done so? In the present context, an examination of these issues includes investigating the circumstances when the law of negligence might require a private doctor, a team doctor or a sport administrator (as a knowing recipient of confidential information relating to an athlete's infection) to take action to protect third parties in sports from the risk of transmission of an infectious disease by warning others of the athlete's infection or taking other protective action. In other words, does any such omis-

141. See *HIV Infection, Confidentiality and Discrimination*, 157 MEDICAL JOURNAL OF AUSTRALIA 282 (1992); *Behringer v. Princeton Medical Center*, 592 A.2d 1251 (1991).

142. See *The Australian Nursing Federation, Policy Statement, HIV/AIDS AND THE NURSING PROFESSION*, December 1991; The New Zealand Medical Assoc., *Policy on HIV Testing, Patient Care and Responsibility* (contained in the NZMA policy document, *Policy Relating to HIV/AIDS*, developed in the period May 1990 - April 1991).

143. *W. v. Egddell*, 1 Ch 359, 419 (1990); *Lion Lab. Ltd. v. Evans*, 1 QB 526, 537 (1985); *Duncan v. Medical Disciplinary Comm.*, 1 NZLR 513, 521 (1986); *Furniss v. Fitchett*, NZLR 396, 405-6 (1958).

sion to act constitute a breach of a duty of care in the tort of negligence owed to that third party?

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

The issue of when there may exist an obligation to disclose confidential information has received considerable attention in American jurisprudence. Some American courts have recognized that a doctor may owe a duty to disclose confidential patient information where there is a risk that a patient may cause violent physical injury to third parties.¹⁴⁴

In several early cases, American courts have also held that a doctor treating a patient for an infectious disease owes a duty to exercise reasonable care in giving notice of the existence and nature of the disease to members of the patient's family and others known by the physician to be in dangerous proximity to the patient.¹⁴⁵

In each of these cases the doctor's duty was recognized in circumstances where the patient was either a child, a person unaware of the disease they were suffering, or a person who could not, by choice, eliminate the risk of infection to others. The cases fall short of indicating that a doctor would be liable where an adult patient who was aware of their infection, and who could have prevented it, engaged in activities (for example, sport) which resulted in transmission. *Tarasoff's* case, however, supports the extension of liability in the sports-transmission context, by recognizing that a doctor may be liable for a patient's voluntary, irresponsible or risk-laden behavior, once injury to third parties becomes reasonably foreseeable. If a doctor knew that an HIV/HBV/HCV infected patient would continue to play sports, there is some American support for the view that the doctor might owe a duty to protect other ath-

144. *Tarasoff v. The Regents of Univ. of California*, 551 P.2d 334 (1976). In this case, the California Supreme Court held that the psychiatrist/patient relationship may support affirmative duties of action which exist for the benefit of third parties; in particular, the duty to protect third parties from reasonably foreseeable harm, which in this case was breached by the failure of a psychiatrist to warn the foreseeable victim of the danger posed by his patient. *Id.*

145. *Jones v. Stanko*, 160 N.E. 456 (1928) (smallpox); *Davis v. Rodman*, 227 S.W. 612, 614 (1921) (typhoid fever); *Skillings v. Allen*, 173 N.W. 663 (1919) (scarlet fever); *Wojcik v. Aluminum Co. of America*, 183 N.Y.S.2d 351 (1959) (tuberculosis); see *Hofmann v. Blackmon*, 241 So.2d 752 (1970) (tuberculosis). More recently, in Colorado, this duty was upheld on the basis that the nature of the doctor/patient relationship supported a duty to warn of 'the specific risks to specific persons' caused by a patient's illness. *Gammill v. United States*, 727 F.2d 950 (1984) (infectious hepatitis and gastroenteritis); *Shepard v. Redford Community Hospital*, 390 N.W.2d 239 (1986) (spinal meningitis).

letes who might foreseeably be infected in a collision; although whether it would be discharged by excluding infected players, or by warning other athletes potentially at risk, or their team, club or governing body, is another matter. It may even be that in the case of a team doctor, a duty to warn may be more readily established toward teammates of the infected athlete than opponents because of the team doctor's existing doctor/patient relationship with the teammates (but not the opponents).

Arguably, the legal position in Australia is even less clear. As a matter of general principle, a duty of care in the tort of negligence will arise when: (1) there is a reasonably foreseeable risk of harm to the plaintiff; (2) the plaintiff and the defendant are in a relationship of proximity with respect to the alleged wrongful conduct and the injury; and (3) there is no legislative or other common law rule precluding a duty in the circumstances.¹⁴⁶ Under Australian law, a doctor, or a team or club administrator, would only be liable in negligence for omitting (intentionally or unintentionally) to warn a third party of harm caused by a patient or athlete where the omission constituted a breach of duty of care owed to that third party.¹⁴⁷

Omissions are conventionally divided into two categories: 'causal', and 'non-causal' or 'pure' omissions.¹⁴⁸ When injury to a person results from an omission in the course of positive conduct there is little doctrinal difficulty in the imposition of liability provided other elements of the tort of negligence are fulfilled. However, subject to a number of exceptions, the law imposes no liability for pure omissions which result in harm, even if that harm is reasonably foreseeable.¹⁴⁹ The analysis appears to apply equally to risks

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

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

148. H. LUNTZ AND D. HAMBLY, *TORTS: CASES AND COMMENTARY*, 494 (3d ed. 1992). Causal omissions can be regarded as occurring in the course of positive conduct; for example, omitting to apply a car's brakes. In the case of pure omissions:

apart from the defendant's failure to act there is no conduct on the part of the defendant which is causally linked to the plaintiff's harm. This is to be distinguished from instances where positive conduct on the part of the defendant is causally responsible for the plaintiff's harm, though an omission in the course of that conduct may also be seen as a cause.

Id.

149. *Home Office v. Dorset Yacht Co. Ltd.*, AC 1004, 1027, 1060 (1970). In its extreme applications, this principle means there is no general duty to go to the aid of drowning or other accident victims. This is usually explained by saying that where a defendant fails, by omission, to prevent a reasonably foreseeable but independently created risk of injury to the

caused by act of nature or the deliberate or negligent conduct of others (as in the present context where the medium of transmission of the disease will be the action of an independent person - the infected athlete).

Courts have, however, recognized a number of special relationships which by their nature involve the assumption or imposition of affirmative duties of action for the benefit of third parties; *i.e.*, liability for pure omissions. In rationalizing the cases, it is helpful to see these relationships as arising in either of two ways. First, affirmative duties of action may be imposed or undertaken by virtue of the defendant's relationship with the direct wrongdoer. The cases suggest that protective responsibilities may arise where the defendant owes a duty to control or supervise the activities of the person who directly caused the injury, and where the injury which occurred was a reasonably foreseeable consequence of negligence in that control or supervision.¹⁵⁰ The 'control' principle has been applied to parents¹⁵¹ and kindergartens¹⁵² in respect of injuries caused by children, and may also explain liability imposed upon prison authorities¹⁵³ and driving instructors.¹⁵⁴ Second, a positive duty to protect may be imposed or undertaken by virtue of the defendant's special relationship with the plaintiff who is injured, rather than with the direct wrongdoer who causes the harm. It is this basis, rather than the abovementioned 'control' rationale, which provides a possible explanation for cases in which liability for failure to act was imposed upon hotel managers,¹⁵⁵ employers¹⁵⁶

plaintiff, the relationship between the defendant and plaintiff lacks that element of 'proximity' necessary to impose on the defendant a duty of care. *Id.* at 502. Alternatively, the intervening act of the direct wrongdoer may be seen as a *novus actus interveniens* which breaks the chain of causation between the defendant's omission and the plaintiff's loss. *Weld-Blundell v. Stephens*, AC 956, 986 (1920); *Smith v. Littlewoods Ltd.*, 1 AC 241, 272 (1987).

150. *Dorset Yacht Co. v. Home Office*, AC 1004 (1970). Home Office was liable for failing to take reasonable care to control some Borstal boys, who escaped from an island where they were encamped and damaged a nearby yacht, on the basis that such escape and resulting damage were precisely what should have been foreseen. *Id.*

151. *Smith v. Leurs*, 70 CLR 256, 260, 262 (1945); *McHale v. Watson* 111 CLR 384, 386-87 (1964) (holding that parents may be liable for injuries which children have caused third parties to suffer in circumstances where the parent failed to exercise reasonable control over the activities of the child).

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

153. *L. v. Commonwealth of Australia*, 10 ALR 269, 281 (1976); *Ellis v. Home Office*, 2 All ER 149 (1953) (determining prison authorities may be liable for failing to take reasonable care to prevent prisoners from assaulting other prisoners).

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

155. *Chordas v. Bryant (Wellington) Party Ltd.*, 91 ALR 149 (1988) (asserting hotel man-

and even a local council patrolling a beach swimming area.¹⁵⁷

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

It is difficult to predict what other kinds of relationship between the defendant and the direct wrongdoer, or between the defendant and the injured plaintiff, would be regarded by courts as displaying that element of proximity sufficient to impose on the defendant a positive duty to act. J. Deane, however, has stated that the categories of case importing affirmative duties of action should be seen as 'exceptional'.¹⁵⁸ He has suggested that apart from cases where a duty to prevent harm caused by the direct wrongdoer is implicit within a particular relationship, or is assumed under the circumstances, a duty to prevent harm caused by the independent action of another will be largely confined to cases involving reliance upon a defendant's discharge of powers, duties or functions arising from statute, from the holding of an office, or from the possession or occupation of property.¹⁵⁹ This largely explains the cases cited above, and would appear to embrace the categorization of cases we have offered.

The limits upon the contexts in which 'protective responsibilities' may arise appear to preclude any duty by a doctor with respect to a private patient, except when the patient is in the custodial care of an institution. This would also generally be the case for any duty owed by team doctors or sports administrators in respect of adult athletes. However, before reaching any firm conclusion on the latter issue, it is essential to analyze both the relationship between team management and an infected athlete who transmits the infection, and the relationship between team management and other athletes at risk (potential plaintiffs), particularly those on the same team. Even so, a team's responsibilities in regard to the

ager's duty to protect one patron from the foreseeable risk of injury from the acts of another patron).

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

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

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

159. *Id.*

activities of an HIV/hepatitis infected athlete arise not from custodial responsibilities, but from contractual and other voluntary arrangements entered into by athletes and the team. Similarly, a duty to control infected athletes and to protect uninfected ones does not appear to arise from any relevant statute, or from government office or from ownership of property.¹⁶⁰ Nor, unlike the parent/child relationship, is the team doctor/sports administrator and adult athlete relationship clearly one where a duty to protect is regarded by law as being undertaken or implicit from the circumstances. Nevertheless, the dividing line between the cases referred to above where there is a duty to take positive action, and the team doctor or sports administrator, who decide on the fitness of an athlete, is a narrow one.

On the basis of the principles discussed above, it is more likely that a duty to protect against HIV/hepatitis transmission would arise within a school sports context. Here, courts may regard the duty of the educational authority to control children while at school as establishing a requisite relationship of proximity which would require the school to take reasonable care to protect other school children from the risk of HIV/hepatitis transmission from a child known to be infected. Alternatively, an omission to act might be seen as arising from an obligation owed directly to the pupil who is placed at risk of contracting the disease. Professional team sports may also attract positive duties to act. Members of professional sports teams are employees¹⁶¹ and as such are owed various non-delegable duties by their employers.¹⁶² Team doctors may not only be at liberty to disclose confidential information to team management, a failure to do so and a failure to act on it by team management may be a breach of the special relationship with employees.

The kind of action, if any at all, which the duty of care would require will depend on the workings of the calculus of negligence which is discussed below under Section 6. Obviously, a factor will be the likelihood of disease transmission notwithstanding infection control procedures are followed. Also, in our view, a court deciding what a reasonable doctor or team manager would do in the circumstances for the purposes of the law of negligence, would take into account the interest in protecting confidentiality. Thus, the reason-

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

161. H. Opie, and G. Smith, *Professional Team Sports and Employment Law in Australia: From Individualism to Collective Labour Relations*, 2 MARQ. SPORTS L. J. 211, 216-219 (1992).

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

able doctor would not be required to warn other athletes at risk because their protection can be achieved by means such as excluding the infectious person from participation. In this way there is no conflict between the law of confidentiality and the duty of care requirements.

In summary, it is our view that in the 'bloody combat and contact sports' where there appears to be some meaningful risk of transmission of HIV/HBV/HBC notwithstanding implementation of infection control procedures, schools and professional team doctors and management will have to take reasonable steps (positive action) to protect their own pupils and employees from the risk of contraction of infectious diseases from other pupils or employees in the same school or team. Also, the control exercised over pupils at school suggests that a protective duty might extend to pupils from other schools participating in inter-school sports. However, as noted above, this control does not extend to employee athletes and, therefore, it is unlikely that a duty to take positive action for the protection of opponents of professional athletes will arise. No doubt this will seem curious to many, but it derives from the quite restricted responsibilities which the law recognizes in regard to pure omissions. Where a protective duty exists, the requirement to take reasonable steps may be satisfied by exclusion of the athlete should counseling not achieve voluntary withdrawal. Confidentiality requirements would not permit nor would the duty of care in negligence (given counseling and/or exclusion) require disclosure of the athlete's status to teammates, opponents or the media.¹⁶³

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

163. Care would need to be taken when giving reasons for an athlete's exclusion in order to maintain confidentiality.

would not have become liable for the transmission. Thus, the doctor might be liable to the patient for the whole or a part of the damages awarded to the infected person.

Finally, it is worth noting some implications for community (as opposed to professional or school) sports. On the basis of existing authority, community sports do not give rise to the special relationships necessary for the existence of liability for pure omissions. However, it may be that the organization and undertaking of community sports programs can be regarded as positive conduct in relation to which there is a duty to take reasonable care for the protection of those who participate. On this basis, those managing community sports who are aware of an athlete's infectious condition could owe a duty to exclude infected athletes participating in bloody contact and combat sports. In fact, this approach could even be applied to sports in general, including professional and school sports.

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

V. LEGAL CONSTRAINTS UPON SPORTS ORGANIZATIONS SEEKING TO MINIMIZE TRANSMISSION

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

The World Health Organization Consensus Statement on AIDS and Sports, as well as the ASMF draft *Guidelines for Sport on Infectious Diseases*, leave it up to the individual concerned to decide whether they will continue playing despite HIV/HBV/HCV infection. While continued participation in sports at the physically demanding highest elite levels may impair an athlete's immune func-

tion,¹⁶⁴ it remains true, as Magic Johnson demonstrated during the Olympic Games in Barcelona in 1992, that symptomless HIV infection does not 'impair a person's strength, agility, or ability to breath'.¹⁶⁵ The same may be true of chronic HBV. Where an athlete wishes to continue participating in sports, or where a sport organization wishes an infected athlete to withdraw from the sport, several legal issues arise. These relate to confidentiality, contractual obligations, discrimination and restraint of trade.

A. Confidentiality

Where the confider of confidential medical information (that is, the athlete), reveals to the world that they are HIV/hepatitis infected, this information will, on general principles, cease to be confidential. Information may also lose its confidential quality by virtue of a *confidante's* breach of confidentiality: courts may refuse to further protect the information by injunction, although an action for damages or equitable compensation may be maintained against the confidee.¹⁶⁶ As discussed above, sports administrators or team officials informed of an athlete's infection by the athlete, in confidentiality, or by a team doctor, would, subject to any contract, owe a duty of confidentiality with respect to that information enforceable by an injunction. So long as the risk of infection in the particular sport concerned did not impose upon the club doctor or team administrators a duty to protect third parties from the risk of infection, no issue of a duty to warn, and with it the issue of the limits of the public interest exception to the duty of confidentiality, would arise. As noted, however, this is one area where the law should be clarified to prevent a conflict between legal duties.

B. Contractual Obligations of Sports Organizations

The second issue relates to contractual obligations. Many representative team member agreements and professional player contracts provide for the termination of the agreement or contract either immediately or after a period of time if the physical condition of the athlete precludes his or her participation at the appropriate

164. L. T. Mackinnon, E. Ginn, and G. Seymour, *Effects of Exercise During Sports Training and Competition on Salivary IgA Levels*, BEHAVIOUR AND IMMUNITY, 169 (1992); N. Sharp, and Y. Koutedakis, *Sport and the Overtraining Syndrome: Immunological Aspects*, 48(3) BRITISH MEDICAL BULLETIN 518 (1992).

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

166. See generally, *Attorney General v. Guardian Newspapers Ltd.* (No 2), 1 AC 109 (1990).

level. An athlete suffering an illness caused by HIV/HBV/HCV infection which was severe enough to produce this effect might well have his or her agreement or contract terminated in this way.

Where an injury is sustained in the course of sports participation, the contract may make provision for continued match payments and for benefits under a health-care agreement or pension fund. Thus, if an athlete acquired an infection during the course of duties performed under a contract (for example, from a bloody collision on the field), these provisions would also apply. These benefits will be payable on an 'occurrence' or 'no-fault basis'. Contractual issues may also arise concerning whether the athlete was in breach of a warranty as to fitness made when the contract was executed.

Indeed, some contracts, such as the 1992 NSWRL Playing Contract, include a warranty that the player will remain fit and able 'to perform his obligations under this contract without exposing himself to greater than any usual risk to health or to greater than usual risk of injury'. The NSWRL contract provides that it may be terminated where, because of the player's physical or mental condition, he would be exposed to a greater than usual risk of injury by playing rugby league football. While symptomless HIV infection, for example, may in the future cause illness, there would appear to be no scientific basis for arguing that an HIV infected player was more likely to sustain injury than any other player.¹⁶⁷

C. Exclusion from Sports and Discrimination

The third issue which arises is discrimination. As with any illness or physical or mental disability, it is not unlawful to discriminate against another person in sport on the basis of an infection if that person is 'not reasonably capable of performing the actions reasonably required in relation to the sporting activity'.¹⁶⁸ It is conceivable that this provision might even extend to an HIV infected athlete, such as a boxer, if it could be shown that his or her infection caused slowed reflexes which predisposed him to cerebral injury in the ring.¹⁶⁹

167. See M. J. Mitten, *AIDS and Athletics*, 3 SETON HALL J. OF SPORT L. 5, 28-9 (1993).

168. DISABILITY DISCRIMINATION ACT of 1992 (Cth) § 28(3)(a). Some State Acts contain similar provisions: EQUAL OPPORTUNITY ACT of 1984 (Vic) § 33(3)(a); ANTI-DISCRIMINATION ACT of 1991 (Qld) § 111(1)(b); EQUAL OPPORTUNITY ACT of 1984 (SA) § 81(a); EQUAL OPPORTUNITY ACT of 1984 (WA) § 66N(3)(a); DISCRIMINATION ACT of 1991 (ACT) § 57(a); ANTI-DISCRIMINATION ACT of 1992 (NT) § 56(1)(b).

169. B. D. Jordan, *AIDS and Boxing*, MEDICAL ASPECTS OF BOXING 317, 321 (1992).

However, under the Disability Discrimination Act of 1992 (Cth), an athlete with a symptomless HIV/HBV/HCV infection who is excluded from participation in sports or subject to peculiar restrictions because of his or her infection may complain to the Australian federal Human Rights and Equal Opportunity Commission, alleging breach of §§ 27-8 of the Act. An

Complaints under the Act are investigated and conciliated by the Disability Discrimination Commissioner, who has power to obtain information and documents, and convene compulsory conferences. Matters unable to be resolved by conciliation are referred to the Commission, which may, if it finds the complaint substantiated, make a declaration that the respondent should re-employ the complainant, or that the termination of a contract should be varied to redress any loss or damage suffered by the complainant, or that the respondent should engage in a course of conduct or pay damages by way of compensation to redress any loss suffered by the complainant.¹⁷⁰ Arguably, this would include reinstating membership of a club or competition. The Commission's declarations are not binding upon the parties, although the Commission may institute proceedings in the Federal Court to enforce its determinations.¹⁷¹

Discrimination in sports on the basis of HIV/HBV/HCV status is not unlawful where 'the discrimination is reasonably necessary to protect public health'.¹⁷² The relative lack of documented cases of sports-related transmission make this defense a difficult one to rely upon. Although *public* health is nowhere defined, in our view, athletes participating in a sport with another HIV/hepatitis infected athlete would be entitled to the benefit of the provision, if the risk of transmission were high enough.

In this respect, it is clear that the initial risk of transmission from collisions and blows occurring in combat and contact sports cannot be eliminated by 'after-the-event' procedures such as the 'blood-bin' rule. Thus, if it could be shown that blood spillage, body contact, and reciprocal blood contact during the sport were sufficiently frequent, the Commission might regard it as reasonable to exclude infected players from the sport. It is suggested that the public health exception could well apply to combat sports such as wrestling, boxing and some martial arts, and possibly to rugby union and league, in view of the high incidence of lacerations requiring medical attention.¹⁷³ As mentioned previously, however, the risk of bloody contact between players must be distinguished from the risk of disease transmission, and the Commission might well uphold an athlete's right to participate in sport despite a theo-

athlete suspended on suspicion of infection pending production of a 'clean' report would have the same grounds for complaint, given that the definition of 'disability', for the purposes of the Act, includes an imputed disability. DISABILITY DISCRIMINATION ACT of § 4(1) 1992.

170. *Id.* at § 103(1).

171. *Id.* at §§ 103(2), 104.

172. *Id.* at § 48.

173. *See generally*, H. Seward, et al., *supra* note 38.

retical risk, in the absence of stronger evidence of collision or blow-associated infection transmission. The issue is difficult to predict.

Where an athlete has chosen to reveal their infection to teammates, or where confidentiality has otherwise been broken, the infected athlete may come under intense pressure not to participate from teammates fearful of acquiring a disease.¹⁷⁴ American courts have rejected the argument that the misconceived fears of the public justify discrimination under federal discrimination statutes.¹⁷⁵

If a known infected player remains in a competition, it is possible that opponents will be fearful to play as aggressively, and that this may give the infected player an advantage in the sport. Alternatively, opponents and others may refuse to play the sport with the infected player. Unless the club, governing body, or team applied for and was granted an exemption from the Commission,¹⁷⁶ however, neither of these grounds would justify excluding an infected player under the *Disability Discrimination Act 1993* (Cth).¹⁷⁷

Although the *Disability Discrimination Act 1992* (Cth) applies throughout Australia, it is worth noting that State legislation may also offer a measure of protection. Anti-discrimination legislation in seven jurisdictions variously prohibits discrimination on the grounds of a real or imputed (physical) 'impairment' ('disability' in NSW): in the provision of employment;¹⁷⁸ in the provision of facili-

174. The draft Guidelines for Sport on Infectious Diseases produced by the Infectious Diseases in Sport Working Party provide that where other participants refuse to continue to participate in the sport with the infected person, then the infected person must be informed of the other participants' attitude. The guidelines then provide that "[t]he infected person may then wish to reconsider whether they want to continue to play their sport and if so, the others must decide whether they will remain in the team or sport."

175. See *Doe v. District of Columbia*, 796 F. Supp. 559, 570 (1992); *Casey v. Lewis*, 773 F. Supp. 1365, 1370-1 (1991); M. J. Mitten, *AIDS and Athletics*, 3 SETON HALL J. OF SPORT L. 5, 33-4 (1993).

176. DISABILITY DISCRIMINATION ACT § 55 (1992).

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

178. EQUAL OPPORTUNITY ACT § 21, 21(4)(h) (1984). That section provides an exception where in view of the impairment and the work environment there is likely to be a risk that the person will infect others and it is not reasonable to take that risk; ANTI-DISCRIMINATION ACT of 1977 (NSW) § 49D; EQUAL OPPORTUNITY ACT 1984 (SA) § 67. Section 71 provides an exception where the person suffering the impairment would be unable to perform adequately without endangering himself or herself or other persons; EQUAL OPPORTUNITY ACT 1984

ties¹⁷⁹ or access to premises;¹⁸⁰ by clubs, including sporting clubs;¹⁸¹ and in sports.¹⁸² In NSW, Victoria, Queensland, the ACT and the NT, the legislation would cover symptomless infections, since the definition of impairment includes 'the presence in the body of organisms causing disease'. In South Australia and Western Australia, however, the legislation would only prohibit infection-related discrimination if the subject could show that the infection had caused a 'defect or disturbance [or in SA, a malfunctioning] in the normal structure and functioning of the person's body'. This may be more difficult to show in the case of a symptomless HIV infection,¹⁸³ although not in the case of a chronic Hepatitis infection which, for example, may have caused physical damage (for example, liver damage), although not necessarily physical symptoms.

D. Exclusion from Sports and Restraint of Trade

The general principles of the restraint of trade doctrine applied to sports, and its relation to infectious diseases, have been discussed above. The issue here is whether a sports club or organization would be able to show that the exclusion of an athlete from a

(WA) § 66B (subject to § 66Q); ANTI-DISCRIMINATION ACT 1991 (Qld) §§ 14-15 (subject to [discriminatory] actions which are reasonably necessary to protect public health or to protect the health and safety of people at a place of work: §§ 107-8); DISCRIMINATION ACT 1991 (ACT) § 10 (discrimination is lawful if necessary and reasonable to protect public health: § 56); ANTI-DISCRIMINATION ACT 1992 (NT) § 31 (discrimination is lawful if reasonably necessary to protect public health: § 55).

179. EQUAL OPPORTUNITY ACT 1984 (WA) § 66K; DISCRIMINATION ACT 1991 (ACT) § 20 (§ 31 exempts voluntary bodies; § 56 provides that discrimination is lawful if necessary and reasonable to protect public health); ANTI-DISCRIMINATION ACT 1992 (NT) § 41 (§ 41(2) exempts persons supplying goods, services or facilities for or on behalf of a sporting association; § 55 provides that discrimination is lawful if reasonably necessary to protect public health); ANTI-DISCRIMINATION ACT 1977 (NSW) § 49M (applies to goods and services).

180. DISCRIMINATION ACT 1991 (ACT) § 19; (§ 31 exempts voluntary bodies; § 56 provides that discrimination is lawful if necessary and reasonable to protect public health).

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

182. EQUAL OPPORTUNITY ACT 1984 (Vic) § 33; EQUAL OPPORTUNITY ACT 1984 (WA) § 66N.

183. Although some courts have been prepared to regard asymptomatic HIV infection as a 'defect' or 'impairment' under the legislation: *Hoddy v. Executive Director Department of Corrective Services*, EOC ¶92-397 (1992).

club or competition was a *reasonable* restriction, which went no further than was reasonably necessary to protect the legitimate interests of the club or organization. The effect of the restriction on the plaintiff pleading restraint of trade, and the special interests of other parties may also be considered.¹⁸⁴

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

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

VI. LEGAL LIABILITY FOR INFECTIOUS DISEASE TRANSMISSION IN SPORTS

This section will consider the legal liability which may be incurred when someone becomes infected with HIV/HBV/HCV within the context of sports. The discussion will focus on the liability of the carrier of the infection and of the sports organization. For simplicity, we will assume that both the carrier and the infected person

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

are athletes.

A. Proof of Transmission

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

Under the *HIV/AIDS Preventive Measures Act 1993* (Tas), a person may be required to undergo HIV testing after an incident in which there was a risk of transmission.¹⁸⁵ Similar legislation exists in Victoria, but would currently apply only to those who may have infected accredited health care workers, police officers and prison officers with HIV.¹⁸⁶

B. Liability of the Carrier Athlete

The law is clear that a participant in a sporting contest owes a duty to take reasonable care not to injure other participants.¹⁸⁷ The operation of the duty will take into account the inherent risks of the sport, so that an accidental collision in a basketball game, one athlete stumbling into another in a running race and a tackle in rugby league will not normally be regarded as involving a breach of the duty of care. It is likely, however, that the risk of infection with HIV/hepatitis would not be regarded as an inherent risk of playing sports, since it is not the sort of ordinary, accidental or unavoidable injury inherent in playing the sport. The issue becomes, therefore: what steps must an HIV/HSV/HCV infected athlete take to avoid breaching his or her duty of care to other athletes?

The steps an infected athlete must take to avoid liability will be determined by what the reasonable athlete in similar circumstances would have done. If the defendant athlete falls short of the objec-

185. HIV/AIDS PREVENTIVE MEASURES ACT § 10(2) (1993).

186. HEALTH ACT § 120A-D (1958).

187. *Rootes v. Shelton*, 116 CLR 383 (1967); *Condon v. Basi*, 1 WLR 866 (1985); 2 All ER 453 (1985); *Johnston v. Frazer*, 21 NSWLR 89 (1990). See S. Bronitt, *Criminal Liability for the Transmission for HIV/AIDS*, 16 CRIM. L. J. 85 (1992).

tive standard so fixed, the duty will be broken.¹⁸⁸

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

It is strongly arguable that the risk of collision between participants in open, non-contact sports such as croquet, golf and lawn bowls and, therefore, of transmission of HIV/hepatitis during play is quite far-fetched. However, infections could occur in other ways in the context of those sports¹⁸⁹ and so the reasonable golfer will at least have to consider the possible precautions. In collision, contact and combat sports, the chances of HIV/hepatitis infection range from small to very slight, but they cannot be dismissed as far-fetched. In our view, courts would regard the risk of HIV/hepatitis transmission in such sports as foreseeable.

Given the presence of a foreseeable risk, it is clear that the reasonable athlete may, in balancing the various factors mentioned above, decide to ignore that risk.¹⁹⁰ Bearing in mind that a court in Australia and, to our knowledge, in any other common law jurisdiction is yet to decide the issue in regard to transmission of HIV/hepatitis in sports, we believe that the reasonable athlete would not be entitled to ignore the risk and to fail to take precautions to guard against it. The more difficult question is to identify the precautions dictated by the athlete's duty to take reasonable care.

When examining the magnitude and probability of the risk, we can only rely on the limited knowledge and statistics which are available. The chance of contracting HIV through sports in general

188. *Id. Overseas Tankship Ltd. v. The Miller Steamship Co. Pty. Ltd.*, 1 AC 671 (1967). This will involve two inquiries. First, there is a threshold issue to be satisfied. The reasonable athlete will only take steps to guard against those risks of injury which are foreseeable, in the sense that the risk is not "far-fetched or fanciful". Secondly, if there is a foreseeable risk, the court must

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

Id.

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

190. *Bolton v. Stone*, AC 850 (1951); *Wyong Shire Council*, 146 CLR 40 (1980).

is extremely small, although apparently greater in combat sports (such as boxing) and bloody contact sports (such as the rugby codes). However, this chance must be weighted by the catastrophic consequences of HIV (death following prolonged illness and significant ostracism). The chances of contracting hepatitis, especially HBV, are significantly larger. However, HBV does not necessarily lead to the same fatal consequences and can be a disease from which there is full recovery. Thus, while the chances of transmission of hepatitis are higher, there is a range of consequences with most being less severe than for HIV.

The other side of the balancing up process requires examination of the ' . . . expense, difficulty and inconvenience of taking alleviating action and any other conflicting responsibilities which the defendant may have . . . ' This examination must be made in respect of identifiable precautions which a reasonable athlete might take. The first of these would be to adhere to the relevant provisions of the ASMF Infectious Diseases Policy.¹⁹¹ This would include such measures as strict personal hygiene, not spitting or urinating in team areas, not participating in communal bathing and not sharing towels, shaving razors and drink containers. It would be expected that an athlete *in any sport* would adopt such measures as much for his or her own safety as for that of others, and irrespective of whether the athlete knew or had reason to know that he or she was infected with HIV/hepatitis. We regard these measures as not onerous when balanced against the risks of transmission to others and, therefore, it would be a breach of the duty of care not to implement them. Accordingly, if it could be established that one athlete had infected the other by a failure to follow the ASMF Infectious Diseases Policy, we believe that, absent complicating considerations, the transmitter of the infection would be legally liable for the harm suffered by the infected athlete.

Other precautions which a reasonable athlete might countenance are (1) to warn others that he or she is infectious so that they can make their own decisions whether or not to participate in the sport with the infectious athlete, or (2) to withdraw from the sporting activity altogether. This is on the premise that the athlete

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

knows of his or her infectious state. The corollary of this is that an athlete who suspects that they might be HIV/hepatitis infected or, perhaps, is in a high risk group, has a responsibility to find out about his or her health status.

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

If the athlete participates in collision, contact or combat sports, we believe the position is more difficult because there is the prospect that infection could be transmitted during play notwithstanding strict adherence to the ASMF Infectious Diseases Policy. That prospect appears to increase from collision through contact to combat sports. An announcement that an athlete has, say, HIV could have catastrophic consequences for a professional playing career. It might be expected to end it notwithstanding that the player is quite capable of continuing at the highest levels. Magic Johnson is a case in point. It is, therefore, largely an unreal expectation that an athlete will announce that he or she is infectious with HIV/hepatitis and expect to continue to participate as before. In reality, the issue becomes one of whether the duty of care requires a reasonable athlete to withdraw. Cessation of risky activity has been contemplated by the courts as appropriate if it cannot be continued without creating a substantial risk.¹⁹² Putting aside the substantial emotion which the issue is capable of generating and bearing in mind that this is a novel point, we believe that it is arguable that an athlete who plays a bloody contact or combat sport would be obliged to cease playing the sport while HIV/hepatitis infectious. Accordingly, if it could be established that one athlete had infected the other by a physical contact in a bloody contact or combat sport we believe that, absent complicating considerations,

192. *Bolton v. Stone*, AC 850, 867 (1951).

the transmitter of the infection would be legally liable for the harm suffered by the infected athlete.

C. Personal Liability of the Sports Organization

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

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

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

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

It is also arguable that sports organizations are obliged by their duties of care to undertake an educative role. Just as coaches must inform athletes of the risks of their respective sports and train them in how to deal with those risks, so there must be education in appropriate hygiene and locker-room behavior. Thus, dissemination

of and education in the ASMF Infectious Diseases Policy insofar as it governs athlete behavior might be expected to be a part of the fulfilment of a sport organization's duty of care. Thus, an isolated case¹⁹³ of spread of, say, HBV through a team of young football players because hygiene was not observed in a locker-room could lead to liability for the resultant harm being placed on the relevant club if it had not educated the boys appropriately. This may be regarded as an onerous responsibility for sports and we are inclined to agree. The messages which the Policy conveys are just as much the responsibility of parents, schools and public health authorities. For this reason, government through its sport and health agencies should consider extending financial and other support to sports at all levels to undertake the necessary education. Also, high-profile leagues and sports should be influenced to adopt the Policy as an example to others.

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

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

For the reasons mentioned earlier, we do not believe that there is any such obligation in sports which do not fall within the bloody contact and combat sports category which we have identified. Even for these bloody sports the position is problematic. A test result which is negative does not necessarily mean that the athlete is not infectious because of the 'window' period.¹⁹⁴ Further, how often must testing occur? A negative test today is no guarantee that in a month's time that athlete will not have become infected. Also, using information which is to hand is not especially onerous, whereas establishing and implementing a screening program is administratively and financially expensive. These costs and practical difficulties are permitted to be taken into account in the bal-

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

194. See *supra* notes 70-71 and accompanying text.

ancing up process which would guide the reasonable sports organization in deciding whether to test. This is a factual issue which courts and, in the meantime, sports organizations will have to resolve.

D. Vicarious Liability of the Sports Organization

A part-time or full-time professional athlete playing for a sports team will almost certainly be an employee of that team.¹⁹⁵ Just as any employer is vicariously liable for the negligent acts of an employee performed in the course of his or her employment, so will the sports team be liable for negligent acts performed in the course of employment by the athlete. If an athlete is liable for transmission of infection on the field or in the locker-room as canvassed in Section 6.(a) above, will that make the employer vicariously liable? There would seem reason to believe that the employer team might be held liable, notwithstanding that the athlete may have deliberately disobeyed instructions to inform the team of his or her state of health.¹⁹⁶ This view seems to be supported by a recent decision of the New South Wales Court of Appeal which upheld the liability of a rugby league club for a deliberate on field blow executed by its employee player which amounted to a battery and was in breach of his contractual obligations to his employer club.¹⁹⁷ However, deliberate fighting not connected with the play and motivated by personal spite or resentment is likely to be outside the scope of employment.

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

VII. INFECTIOUS DISEASES IN SPORTS - GENERAL CONSIDERATIONS

A. Rationalizing Conflicting Rights and Obligations

The tension between (1) the interest a club or sports organization may have in reducing the risk of infection transmission, and liability for such transmission, by introducing mandatory HIV/hepa-

195. H. Opie, and G. Smith, *Professional Team Sports and Employment Law in Australia: From Individualism to Collective Labour Relations*, 2 MARQ. SPORTS L. J. 211, 216-219 (1992).

196. See further, *Id.* at 320-3.

197. Canterbury Bankstown Rugby League Football Club Ltd. v. Rogers, Aust Torts Reports ¶81-246 (1993).

titis testing, and by excluding infected athletes, and (2) the career and professional interests of infected athletes, has been evident in several contexts in this paper. We have discussed how these conflicting interests will be affected by the law relating to discrimination, restraint of trade and confidentiality, by the imposition of protective duties, and by the principles regulating liability in negligence for HIV/hepatitis transmission.

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

In seeking to rationalize the effect of all the legal doctrines and issues we have discussed, the legal criterion of *reasonableness* stands out.¹⁹⁸ Whether restraint of trade protects an athlete from exclusion for refusing to undergo a test or for being infected depends upon the criterion of reasonableness. Whether an HIV/hepatitis infected athlete will be liable if he or she transmits an infection in the course of participating in a sport will depend upon whether, *by not issuing a warning or excluding himself or herself*, the athlete was taking reasonable care with respect to an otherwise foreseeable risk. Likewise, whether a team doctor or administrator with knowledge of an athlete's infection, would be liable for failing to warn other participants in the sport of the athlete's infection, or for failing to withdraw the athlete, would depend upon whether reasonable care with respect to an otherwise reasonably foreseeable risk required a warning, or exclusion, assuming the relationship was one into which a protective duty for the benefit of other athletes was imposed.

The criterion of reasonableness does not, of course, determine the application of every doctrine relevant to the issue of infectious diseases transmission. In breach of confidentiality, for example, it is the balancing of competing public interests, and not 'reasonableness', which determines whether the disclosure of confidential information may be justified under the public interest exception. Reasonableness is nevertheless important in maintaining a coherent

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

relationship, and in avoiding conflict between different legal doctrines. How these doctrines interact with the risk of HIV/hepatitis transmission will, as noted above, depend on scientific evidence of the risk. As presently advised, however, there would appear to be three general conclusions which we can make about the application of law to the issue of HIV/hepatitis transmission in sports.

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

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

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

B. Recommendations

These arguments, as emphasized at the outset, arise from the application of general principles to the novel context of infectious diseases in sports; any conclusions are necessarily tentative, as courts have not yet been called upon to resolve the competing interests involved. While doubt remains, however, there are some important recommendations we can usefully make. First, it is important that sports policy be guided by scientific fact, and that sports administrators, and athletes, be educated of the risk of HIV/hepatitis transmission both on and off the field. Secondly, sports administrators at all levels would be advised to implement infection control guidelines such as those advocated by the Australian Sports Medicine Federation, in order to minimize the risk of infectious disease transmission. Thirdly, the HBV immunization of athletes playing combat, contact and even collision sports, as a means of minimizing HBV transmission, is an obviously important option for sports organizations, subject to financial constraints. Fourth, in view of our analysis, sports administrators responsible for bloody contact and combat sports would appear to be justified in excluding infected athletes and possibly advised to implement mandatory testing.