Sex and HIV
Sleeping with the enemy?

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The obligations of both parties to sex where HIV is involved are untested, unclear and complex

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The war

Much of the language surrounding HIV/AIDS uses the metaphor of war — 'the fight against AIDS', 'the casualties in the AIDS war', and 'the HIV enemy'. This article explores legal issues relating to sex when one partner is HIV-infected, and includes such areas as civil liability for HIV transmission, the commercial sex industry and public health offences. The background material for this article comes from three series of Discussion Papers issued by the Legal Working Party of the Intergovernmental Committee on AIDS, in particular 'Legislative Approaches to Public Health Control of HIV-infection' (February 1991), 'Legal Issues Relating to HIV/AIDS, Sex Workers and Their Clients' (July 1991) and 'Civil Liability for Transmission of HIV/AIDS' (forthcoming in March/April 1992).[1]

Sex and the law

Sex can be part of an intimate relationship involving trust and love, a consensual physical encounter involving neither of these, a commercial transaction, or a combination of some of these elements. The legal responsibilities vary according to the nature of the relationship, but the potential for HIV transmission is universally determined by personal behaviour, such as safer sex measures. According to the *National HIV/AIDS Strategy* released in August 1989, everyone must accept responsibility for preventing themselves from becoming infected through sexual intercourse. The law, however, gives a more complex message. The concepts of consent and contributory negligence help place responsibility on everyone for their own health, but people who know (or even ought to know) that they are HIV-infected have an additional legal responsibility not to infect others, given that they now have the power to do so.

Civil liability for HIV transmission, and even exposure in some circumstances, exists under the intentional torts of battery, deceit and nervous shock, and also negligence. No actions have yet been commenced in Australia or the United Kingdom, but some have been filed in the much more litigious United States following precedents set in earlier cases involving transmission of venereal diseases such as genital herpes. A critical factor in any case is whether the defendant knew he or she was infected, and whether this information was communicated to the plaintiff.

Battery

Battery consists of the unauthorised, direct application of physical force in a harmful or offensive way. Consent to the acts of sexual contact and HIV transmission is a central issue, and several US authorities exist for drawing a distinction between the nature of these two acts and therefore the scope of consent. An unwelcome precedent exists in the old English case of *R v Clarence* (1988) 22 QBD 23 which held that only fraud as to the nature of the act itself (e.g. pretending it was a medical procedure) or the identity of the defendant could destroy a wife's consent to sex with her venereally infected husband. Whether this case is still good authority today is highly debatable, especially since the House of Lords now recognises rape in marriage. In a battery case it is necessary to prove that the defendant intended to infect the plaintiff, which could be inferred from the plaintiff's knowledge that he or she carries the virus and modes of transmission (which should be explained in counselling accompanying testing for HIV antibodies). Express intention would only rarely exist, but exceptional cases have been reported in the USA where men have allegedly stated that they wanted to 'take as many with me as I could' or have mockingly revealed their HIV status immediately after the sexual act.

Deceit and fraud

Deceit or fraud consists of a misrepresentation by the plaintiff to the defendant that he or she is not HIV-infected, made with the knowledge of its falsity or without genuine belief in its truth, and with the purpose of inducing the plaintiff to act in reliance on it, i.e. to have sex. Liability is clearer when the plaintiff actually asks the defendant if he or she is infected before consenting to sex, or the defendant volunteers information that he or she is not. The situation is much less clear where the defendant is silent unless a fiduciary relationship exists between the parties so as to place an affirmative duty on the defendant to disclose his or her HIV status. There have been cases in the USA giving a spouse the right to know of the existence of any disease which might have a bearing on the marital relationship. It seems unlikely that corresponding rights/duties would be found by the courts in cases involving 'one night stands'.

Nervous shock

Intentional infliction of nervous shock exists where an act is wilfully done and calculated to cause physical harm. It is not merely grief, sorrow, anxiety or depression which are normal reactions to stressful experiences, but must be a recognisable psychiatric illness such as 'AIDS phobias' following repeated negative diagnoses. In Marc Christian's action against Rock Hudson's estate, he was awarded $US5.5 million in damages for exposure to HIV.[2]

Negligence

A much more likely cause of action for sexual transmission of HIV is negligence, rather than intentional torts, because it focuses on conduct rather than the plaintiff's state of mind. Negligence exists where there is a legal

duty to conform to a specified standard of conduct which has been breached, and there is a proximate causal connection between the defendant's conduct and the injury to the plaintiff. The relevant standard of conduct is measured by reference to the reasonable man unless there is a prescribed legislative standard, such as public health HIV transmission/exposure offences which exist in many Australian jurisdictions. In New South Wales, an HIV-infected person is prohibited from having sexual intercourse with another person unless that other person has been informed of the risk of transmission and has voluntarily consented. In Victoria it is an offence to knowingly or recklessly infect another person, whether by sex or other behaviour without his or her consent to such a risk. Queensland has a similar offence for knowingly (but not recklessly) transmitting the virus, except that only spouses can consent to the risk of infection. In South Australia it is an offence for an HIV-infected person not to take reasonable measures to prevent transmission of the virus to others, e.g. use of condoms which are certainly 'reasonably' safer sex measures.

Interestingly, because of the way HIV/AIDS has been categorised under old public health legislation in Western Australia and Tasmania, no analogous offences exist for having unsafe sex, but inappropriate offences are applicable which were developed for diseases having casual modes of transmission, such as renting shared accommodation, handling clothes in a factory, catching a bus without telling the driver that you are infected etc. Thus the standard would seem to be in many jurisdictions that you can only have sex if you are HIV-infected if you obtain the consent of the other party. The Legal Working Party has proposed that insistence on or agreement to safer sex measures be made a partial defence to such an offence, i.e. a lesser penalty would apply.

Defences

Community groups have argued that a complete defence is necessary for safer sex measures, as is the case for consent to the risk of transmission. The Legal Working Party reaffirmed its view in the Sex Workers Discussion Paper that a full defence was not appropriate for safer sex, as it considered that the risk of transmission should be known and consented to by both participating partners, even if the risk is small, e.g. a condom breaks, or genital/oral lesions are present (although these are less likely to occur in commercial sex, and the risk of transmission is reduced in single episodes of sex). Whilst this is an ideal approach, there is an accompanying danger in leaving a stigma of criminalisation (even if lesser) on changed behaviour such as safer sex in sub-cultures such as the gay community, where there may not be any expectation of disclosing one's HIV status in casual, as opposed to long-term sexual liaisons. There have been reports, however, of a successful male sex worker in one city whose clients are aware of his HIVstatus and are confident to mutually consent to safer sex because they do not personally consider the risk of transmission to be significant.

In a negligence action the way to establish whether a duty exists to avoid conduct involving unreasonable risk to others is through the *Donoghue v Stevenson* [1932] AC 562 at 580 'neighbour test', as well as foreseeability of harm (i.e. transmission of the virus) within the context of the varying sexual relationships between parties. The intimate nature of sex would clearly satisfy the neighbour test, and foreseeability could be established where a defendant knew he or she was infected and what the modes of transmission were. In the USA commentators have argued that people engaging in 'high risk' behaviour have a duty to determine whether they are infected if they wish to continue such activities without safer sex measures or warning prospective partners of their sexual history. In Australia, only the Northern Territory has a statutory obligation to determine one's HIV status. Under s.7 of the *Notifiable Diseases Act* 1981 (NT) a person who has reasonable grounds to believe that he or she is infected must consult a doctor at the first reasonable opportunity. A less clear interpretation provision is found in Victoria under s.119(c) of the *Health Act* 1958 which states the principle that a person who suspects that he or she is infected must ascertain whether he or she is infected and what precautions should be taken to prevent others being infected. As stated above, s.120(i) also provides for the offence of recklessly, as well as knowingly, transmitting HIV, which more clearly places an onus on persons who reasonably suspect that they are infected. Wilful blindness to the posibility of being HIV-positive may constitute recklessness.[3]

It is difficult to know in the abstract whether it is fairer to impose a duty on a plaintiff to inquire as to the defendant's HIV status, rather than requiring the plaintiff to disclose his or her status voluntarily. Contributory negligence, because of its ability to apportion responsibility flexibly, is a useful concept to apply to individual fact situations. It also deters both parties from negligent conduct, rather than just one as is the case with voluntary assumption of risk. Apportionment legislation has been introduced into Australia from the 1930s to 1960s whereby a court can reduce the damages recoverable to the extent it thinks it 'just and equitable having regard to the claimant's share in the responsibility of the damage'. An example could be a couple who meet in a seedy bar where virtually no words are exchanged and they have unsafe sex in a toilet on the premises. The responsibility would appear to be equally distributed in such a situation if one was HIV-infected. Another example is the case of an apparently stable monogamous relationship where both partners earlier agreed to be tested for HIV antibodies before having unsafe sex. Years later one partner has become HIV-infected through an affair which the other partner is not aware of and he does not want to tell the other partner of his HIV status in case the relationship breaks up. In these circumstances it would seem to be reasonable for the monogamous partner to rely on the other, and it would not appear to be negligent to expect the HIV-infected partner to disclose his status.

A similar argument could, however, be raised in the first scenario where the person who is not HIV-infected says that he or she relied on the duty of the HIV-infected person to obtain informed consent under public health transmission/exposure offences. The only reply is that contributory negligence for unsafe sex is relevant for civil liability but not criminal culpability purposes. The existence of civil liability can not only act as an incentive for HIV-infected people to ascertain their status and act responsibly, but to encourage everyone to look after their own health.

Other defences to negligence actions are consent and possibly illegality, as spousal immunity was finally abolished by s.119 of the Commonwealth *Family Law Act* 1975. Consent here is similar to the situation with battery. The plaintiff is aware of the real nature of the sexual conduct in issue, but not of its offensive quality and consequences, i.e.

transmission of HIV. It seems that such a misapprehension affects the genuineness of consent because of the lack of comprehension. Transmission/exposure offences explicitly recognise consent as defence, as the state has decided not to interfere with individual rights to private and mutual sexual expression even though medical and social burdens will accompany further cases of HIV transmission, consensual or not. Consent to an illegal act such as homosexual sex in Tasmania may be recognised by the courts in a civil liability case even though it may be rejected under the criminal law for public policy reasons. Illegality has not been successfully invoked in many USA cases involving adultery, fornication, sodomy and prostitution offences because of the doctrine '*in pari delicto*' (in equal fault).

Problems with proof

Practical evidentiary problems would surround most cases of sexual HIV transmission because of the difficulty of proving who (and whether they knew they were HIV-positive at the time) actually infected the plaintiff, unless multiple partners did not exist or can be conclusively eliminated from responsibility. Causation would be even more difficult to prove in secondary sexual infections, i.e. third party sexual partners who are infected consequent to the primary infection. A new avenue which has only been recently explored since a Florida dentist who died of AIDS allegedly infected several of his patients is DNA sequencing of the virus in the plaintiff and defendant to show unique patterns which would suggest that they were infected with the same strain. More important deterrents to litigation are the existing personal relationship between the parties where blame is not wanted to be cast because the first party did not know that he or she was infected. Where relationships have broken up there are still problems of statutes of limitations, litigation fatigue, legal costs and the defendant's lack of assets, and even on death, his or her estate.

The sex industry

A fascinating hypothetical case of civil liability would be in the sex industry. The Legal Working Party has proposed that laws criminalising the sex industry be repealed, except for offences relating to violence or coercion of minors. If governments choose to have special laws controlling the operation of the industry, then the Legal Working Party has suggested that there should be no registration or mandatory testing of individual workers. If operators are to be licensed, then restrictions could exist for those who breach occupational health and safety requirements, e.g. supply of free condoms, lubricants and sexual health educational material. Such regulations exist in Victoria and it is an offence for an employer to require a worker to provide services without a condom. No special offences were recommended by the Legal Working Party for sex workers or operators for cases of HIV-infected workers continuing to work. General HIV transmission/exposure offences were considered sufficient disincentive for infected sex workers (or health care workers) from activities which involve transmission or a risk of transmission, such as penetrative sex (i.e. not masturbation or fantasy phone calls) whether or not it is of a commercial nature.

These offences also apply to HIV-infected clients who may be attracted to the anonymity of the sex industry, especially where relationships have broken down because they have disclosed their HIV status to partners. If specific offences were only targeted at HIV-infected sex workers, clients would avoid responsibility for their own health and resist using condoms with guaranteed 'clean girls'. In its Discussion Paper on Employment Law and HIV/AIDS the Legal Working Party proposed that employers be prohibited from requiring HIV antibody testing from job applicants or employees, but emphasised the universal responsibility for protecting against infection in the workplace by the enforcement of infection control guidelines. No specific statutory obligation was proposed for employees to disclose their HIV-status to employers because of the adequacy of transmission/exposure offences as recommended by the Legal Working Party, which contain a defence where consent to the risk of transmission is obtained from the other non-infected party, e.g. clients.

However, it was recommended that HIV-infected workers in industries where HIV transmission is possible inform their employer or registration board to clarify their legal obligations, so that they can be transferred to other duties if their present duties involve an unacceptable risk of transmission. Whether or not an employer would be vicariously liable for an infected worker transmitting the virus to a client would depend on whether the employer knew the worker's HIVstatus and if occupational health and safety requirements, such as use of condoms were observed.

If the employer knew the employee's HIV status and allowed him or her to continue working where there was a risk of transmission then vicarious liability would appear to exist, even if a condom broke as the client did not consent to the risk of transmission. If a condom was not used by the client, contributory negligence would clearly be established, but some remaining vicarious liability may exist where the employer condoned this, thereby breaching occupational health and safety requirements. If a worker was infected by a client, this would be practically impossible to prove unless incident reporting procedures existed where condoms broke or HIV-infection was deemed an industrial disease for workers compensation purposes, thereby reversing the onus of proof so that the employer must bring evidence that HIV was contracted outside the workplace. Currently only the Northern Territory has deemed AIDS an industrial disease in certain employment, i.e. hospitals, medical/dental centres, blood banks or laboratories. If an employee wilfully and falsely misrepresents to an employer that he or she was not infected prior to employment, then in all jurisdictions except for New South Wales and Victoria, workers compensation entitlements are forfeited.

Feedback invited

The obligations of both parties to sex where HIV is involved are untested, unclear and complex. They could be clarified. The Legal Working Party has attempted to outline methods of improving the law and would welcome readers' views on its proposals before a Final Report is released in mid-1992.

References

1. Copies of these for making submissions, are available from the Legal Secretariat, AIDS Branch, Department of Health, Housing and Community Services, GPO Box 9848, Canberra, ACT, 2601, tel. (06) 289 6903 — Fax (06) 289 6838.
2. Parker, J., *The Trial of Rock Hudson*, Sidgwick and Jackson, London, 1990.
3. A common law duty to ascertain one's sterility was found to exist in the USA case Alice D v William M 113 Misc. 2d 940, 450 NYS 2d at 354, where the defendant negligently impregnated the plaintiff after honestly misrepresenting that he believed he was sterile.