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HIV/AIDS: Confidentiality and Third Party Notification

Lessons from Compared Law (England, Germany, Spain)

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2 Introduction: HIV/AIDS nowadays. Precedents and legal preconditions

Where Law cannot fulfil its function efficiently
It should desist from taking any action

Prof. Carlos María Romeo Casabona[1]

This report should base on the double assumption of an achievement: Everyone knows today how the HI-virus[2] transmits and that this rather difficult communicable pathogen almost certainly can produce a potentially deadly human illness called AIDS after a long latency period.

That this general knowledge assumption may unfortunately not be completely true[3] (at least everywhere or in every situation) can also be understood from the still increasing infection and mortality figures worldwide - presuming a rational or logical cautious human handling[4]. Nevertheless, that supposition is a fact in the countries analysed in

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[1] Interview: 22nd April 2005. Comp. Romeo 2002.

[2] HIV was first also medically called: HTLV-III (Human T-cell Lymphotrope Virus) or even LAV (Lymphadenopathic Associated Virus). CDC/MWMR 1986; Legal/Legal 1986, 13; http://www.online-medical-dictionary.org/?q=~Ht (3.12.2004).

[3] Information can be inaccurate or incomplete. Even the known statement - HIV infection only through contact of own blood with blood, semen and vaginal fluid of HIV carriers - could have its exceptions: HIV has already been isolated in saliva (and sweat, tear fluid, etc.). Although not one case of infection through these bodily fluids has been reported so far, as the virus quantity in these cases seems not to be sufficient to cause an infection, this possibility can not be excluded (Denner 2001; Bengel 1993, 67 ff. S. www.cdc.gov/hiv/pubs/facts/transmission.htm, 28.4.2005).

Concerning the second assumption - HIV derives to AIDS derives to death - a deadly end can be avoided or long delayed with appropriate treatment and with its observance. At least until virus resistance or the infection with a different HIV kind happens: http://web.amfar.org/treatment/HIV+/APRSPAN2002.pdf, 23.10.2004. And HIV does not always (rather exceptionally, though) produce AIDS.

[4] CFR 2005; UNAIDS/WHO 2003; 2004: The number of HIV cases and deaths due to AIDS grow year after year (both have in 2004 reached the highest level ever), especially in areas where a knowledge assumption might be exaggerated - in sub-Saharan Africa (though starting to stabilise) and in (Eastern) Asia - but also in Eastern Europe, even after a general improvement of the treatment methods and the spread of information and prevention strategies (López 2005; comp. El Mundo 2005). In fact, AIDS is one of the first mortality causes in the world - http://www.igerontologico.com/salud/escuela/sida.htm (28.4.2005) - that can potentially bring certain of the above named regions to an economical, social, political, legal and military collapse, as sexually active people are preferent targets of HIV, as much as the most productive part of society (CFR 2005; Runkel 2003, 123; 162 ff; UN-Resolution 1308/2000).

this essay: England (and other common-law-states), Germany and Spain. This statement roots in their empirical reality and in the background of their legislation and court decisions[5], even if, certainly, in some concrete cases reality could be proven differently, and if their similar legal/ethical basis could occasionally show divergences.

However, this knowledge assumption is pivotal for some essential implications for their present Law (and also Ethics), which are also relevant in this essay, such as:

- Given that people know the disease and the pathogen they are facing, emergency, disproportional or unreasonable legal measures can be reduced to a minimum[6].
- People are aware of situations where they put themselves or others at risk, irrespective if more information on the concrete case is available - e.g. irrespective if disclosure or notification about eventual carrier status took place or not and how it did.
- It is undisputed who are or could be the third persons involved: Those who engage in activities which imply that their own (blood) circulatory system be in contact with HIV infected blood or with the other (potentially) risky bodily fluids, as well as, indirectly, informed general practitioners (GPs)[7].

With this basis it is important to underline that a first background of urgency or danger is now absent, so it is possible (and necessary) to have time to evaluate the

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In high-income countries the trend is different however (UNAIDS 2004, 28 ff). The mortality rate decrease, due to a widespread access to antiretroviral treatment, nevertheless - or perhaps also for this reason - the number of people living with HIV continues to rise in these countries as well (Comp. Martínez 2004).

This worldwide increase of HIV infections could be independent from the assumed general knowledge, which show that information or knowledge alone is not enough to stop the pandemy: For instance it could be related to less logical or objective human temerity, to careless handling with blood transfusions, to involuntary contact with the HIV (transmissions in the window period, etc.) or to other reasons, not always easy to prevent - e.g. rape (as war weapon) or needle sharing among drug addicts, especially in prisons.

[5] S. below. Comp. Jean 1991, 29.

[6] R (87) 25, 26th November CoE. Communication 15th May 1987; 31st May 1988.

Essential is that ignorance does not interact with social alarm. This is important if we compare HIV/AIDS with the outbreak of new (fatal) diseases, like it was the case in the late nineties until 2001 (nvCJD), in 2002 (SARS), or in 2003-5 (avian influenza),. Comp. Knobler et al. 2004; Piot et al. 2004; Selgelid 2003.

[7] The context of this report is just the practitioner-patient relationship. Other concerned third persons - health authorities, employers, assurance companies, prison staff, etc. - will not be considered.

social impact of any measure to take[8]. What is more, Law is set in a position to ensure a more adequate balance between all rights and interests implicated, i.e. a more homeopathic approach (*ut aliquid fiat*). Preventive measures and other duties for patients to observe may thus be maximally reduced, what guarantees a higher respect for everyone's liberty and autonomy, as much as a less stringent intervention of Law.

A less restrictive, more respectful and better tailored Law makes it indirectly possible - apparently paradox at first sight - to prevent more efficiently disease spreading, at least as far as people are concerned[9]. E.g. by avoiding stigmatisation and by promoting cooperation and compliance, or by letting people's attitudes change by themselves. Law remains active above all by giving information and support (e.g. with aid measures) to those affected, what will promote that they will be more ready to work together with health authorities and at their own healing[10].

It is unquestionably true that Society and Law accept a certain risk with this almost exclusively reactive - i.e. *a posteriori* of any (potential) damaging action - legal attitude, but this risk is assessed not to outweigh the personal costs of constraining people's fundamental rights, the psychological-social costs of a higher level of stigmatisation or the economical costs of every kind as a result of repressive legal methods. And, as it was seen, such respectful approach will lead to the prevention of further transmissions[11]. By the way: This approach will make possible a further diminishing of rights restrictions[12].

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[8] Comp. Eirmbter et al. 1993; Rosenbrock 1987.

[9] Comp. NAT 2004; UNAIDS 2002; MSC/CGPJ 2000; Montilla 2000; Gasner 1999; DASPL 1990; comp. UNGASS Declaration: www.unaids.org/en/events/un+special+session+on+hiv_aids.asp (29.4.2005). Also the German act on the Regulation of Working Relations of Prostitutes (*ProstG*) could be a good example how Law can be counterproductive by trying to comprehend and rule society, when complex private interests are involved, and even achieve the contrary of what it pursues (comp. Schmidbauer 2005).

[10] At a more general national or international level the assignment of Law and Politics is to foresee possible scenarios in order to fight more efficiently infectious diseases, so that the appropriate means be ready to assure prevention and treatment, and the efforts at all levels be coordinated when the critical time comes (s. e.g. Piot 2004; Ferguson 2004; KF 2004).

[11] S. 9. To seek patient compliance at a voluntary basis, (even if) additionally supported by some economical incentives, reduces considerably costs - illness treatment, spread, etc. Montilla 2000, 203-4; Cobreros 2000, 119; 1996, 347. Comp. Danzer et al. 2002.

[12] Comp. Gómez Pavón 1997, 194; SSTC 254/1988, 21st December; 91/2000, 30th March; comp. UNAIDS 2002; Walford v Miles [1992] 2 AC 128.

This is probably the most important implication of that information and knowledge assumption in the HIV/AIDS context: Law is allowed (or perhaps rather obliged) to the greatest possible extent to refrain from taking repressive actions or measures against HIV carriers, but to support and help them, which is also the most effective epidemiological strategy to fight this disease and the spreading of HIV[13]. HIV carriers are assured (back) the use of their fundamental rights and freedoms beyond any paternalistic legal view[14].

Law's action in this regard is therefore constrained to reaction: Given that freedom and autonomy are a necessary and sufficient condition of responsibility, (only) if HIV carriers (as any other citizen) make a wrong use of them, they will have to account for their actions before the Law and Society. At this point the advisable legal subsidiarity - *laissez faire* - has to conclude so as to protect higher levelled collective goods.

As practically no restrictive (or primary) preventive Law is therefore required in case of HIV/AIDS, the following pages will mainly focus on reactive Law.

3 Room for legal reaction

HIV carriers will have to observe very few preventive measures, that however cannot be imposed by force, all directly aiming at protecting third persons. For it is factually a correct expectation that most people do not want to jeopardise (or to be jeopardised by) others[15]: So our assumption, they will know when this happens (by engaging in

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[13] Comp. Gostin 1995; Vidal/Alventosa 1992; Murard/Zylberman 1991, 23. In fact, despite a real risk basis, HIV+ persons were very soon freed (almost everywhere) from restrictions or obligations (s. fn 14).

[14] Comp. Eberbach 1991, 79. This was not always the case, above all at the beginning of the AIDS pandemic expansion, as the situation and the available information were much different as they are now. Some paradigmatic preventive measures concerning HIV+ were: Imprisonment, isolation and quarantine in Cuba, USA and China; compulsory bodily analysis in Sweden (though never applied) in the USSR and in some US-States; vigilance of HIV carriers' sexual partners in Hungary, etc. (s. Wierzba 1996; Jayasuriya 1995; Vidal/Alventosa 1992; Leskien 1988). At that time though people themselves pleaded for such restrictive public interventions (Runkel 1989a, 15 ff: e.g. obligatory registration of HIV-infected).

Nevertheless it may be unavoidable in fighting AIDS to accept exceptional right restrictions even at present. E.g. the WHO itself proposed compulsory HIV-analysis as a condition of legal marriages in Salangor and some other states in Malaysia (EFE 2005).

[15] "Irresponsibility is no mass phenomenon (under the precondition that people are informed about the right acting)… and so any legal intervention will be then crisis intervention" (Eberbach 1991, 80. Comp. Runkel 2003, 153). And though, irresponsibility appears in some risk groups not to be uncommon

unprotected sex, by using others' syringes or razors blades, etc.) and then try to avoid it.

The next pages are dealing therefore with this accepted (and as little expected) risk - the mentioned abuse of responsibility and their consequences -, i.e. with the reaction against HIV infected if they endanger intentionally, recklessly or negligently other people's health or lives. The main focus is Criminal Law (CrL), together with Civil Law, as much as the liability of HIV infected for any damage compensation is concerned[16].

As a paradigm, only (unsafe) sexual activities[17] of HIV infected persons[18] who know this health condition and hence their duty to disclose it to their sexual partners in the cases, where all individuals involved have legal capacity to consent and to act, are to be considered in this report. In order not to extend too much its limits, only two legal questions will be faced, both regarding third party notification and HIV carriers: The disclosure duty of HIV carriers to their sexual partners *and* the duty of confidentiality of physicians and its limits (emergency disclosure), in case of infection risk/danger for those sexual partners, when the disclosure of the HIV infected person fails.

3.1 Duty of HIV carriers to disclose their condition to their sexual partners

If we take as *praesumptio iuris tantum* the assumptions of this paper for granted and consider seriously freedom and privacy as fundamental rights, we can even doubt if and when there is a disclosure duty for HIV carriers vis-à-vis their sexual partners.

For this legal disclosure duty, i.e. as basis to assume legally the responsibility of HIV infected on others, we can argue that although this pathogen is not easily

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(Gorbach et al. 2004; Ciccarone et al. 2003. S. Runkel 1989, 8; 1989a, 19: The readiness to inform sexual partners or to change sexual behaviours is high, but not unanimous).

By the way, Prevention is also worth by HIV carriers themselves, as any new infection can result in a higher seriousness of their symptoms (Leskien 1988, 173)

[16] Seuba 2002; Wierzba 1996; Díez Pita et al. 1997.

[17] Only those that pose a significant risk of HIV transmission (mainly anal or vaginal coitus and oral sex) are here to be included in this concept. They will be "unsafe" if semen, vaginal fluid or blood of the HIV carrier can be in direct contact through these sexual activities with the victim's circulatory system.

[18] Nowadays, at least in the three countries under analysis, the most frequent cause of HIV transmission (Barba 2004).

transmissible[19] and that in case of infection the development to AIDS may take very long (or, exceptionally, even not happen), its damaging consequences can be enormous - death *ad maximum*, even nowadays. Moreover, everyone obliges the principle *naeminem laedere* (cause no harm).

Against this disclosure duty it might be asserted according to our assumption that any (capable) person is aware of the situations where he takes risks and can (and should) take measures responsibly to prevent them. Besides - eventually extreme - negative social (and then psychological) consequences for those HIV infected are after disclosure to be expected.

So it seems at first sight fair that the responsibility as a result or eventually for the consequences of sexually risk activities may be shared between those involved.

To conclude, however, that responsibility should be shared at the same ratio between them could challenge the principle of justice. The knowledge advantage of the HIV carrier (that he can *really* transmit HIV, as it is not a mere possibility any more), which could deny the validity of the victim's consent - as without it, it cannot be ascertained that the person acted autonomously -; and the risk of enormous harm (death) should weigh heavier in the concrete situation than the victim's general knowledge of the HIV/AIDS transmission ways. This paper's assumption alone - or together with the eventual negative effects of forewarning - appear thus not to be able to compensate a disclosure duty of HIV+ persons - i.e., to excuse her non-disclosure by risky sexual activities -, even if that presumption or negative effects may play a role in some contexts.

By the way, a logical precondition of an obligation to forewarn would be that the concerned persons know about their being HIV carrier before the practice of the potentially unsafe sexual activities and not afterwards[20], as only from that moment on

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[19] E.g. the infection rate by women, who face a greater risk compared to men, is (by unprotected sex with ejaculation): vaginal sex 0.8%; oral sex, 0.05-0.1% (http://elmundosalud.elmundo.es/elmundosalud/ especiales/2003/12/sida-10preguntas/index.html, 22.2.2005). S. BGHSt 36, 262, 12th October 1989.

[20] UNAIDS 2002, 13. Z v Finland (1997) 25 EHRR 371 (ECtHR). The risk is, however, that certain persons that suspect to be HIV carriers may be discouraged to be tested - so that they would not really "know" about their infectivity. Such "wilful blindness" though - if a person may have probably had contact with the HI virus but rejects to test it in order to argue her ignorance - could be under some circumstances criminally relevant and equivalent to knowledge (Chalmers 2002; s. fn 22). The reason is that this use of the right not to know (Art. 10.2. ECHRB), protected by the fundamental right to

they will be able to assume responsibility for being under certain circumstances a potential risk or danger for the life and health of others[21].

An important consequence of that general knowledge assumption with regard to the attribution of legal (specially criminal) responsibility to HIV carriers is that **negligence**, of any relevant form in Law it may be, can not in principle find application in the cases concerned[22]. Every HIV infected who is informed about this condition and engages in risky sex without disclosure and/or protection is supposed *iuris tantum* to know (or should have known) about her being endangering others and about the ways to jeopardise them, which she is obliged to avoid. Therefore, in case of HIV transmission as a result of such sexual activities, only **recklessness** and **intent** can be the questioned as *mens rea*[23]. Consequently, the important and difficult problem to prove intention, which is essential to the attribution of any criminal offence, can be here simplified for a capable person and be partially presumed: From the fact of carrying out those critical activities and from the assumed knowledge on their consequences is at least recklessness to be directly inferred.

However, the main problem concerning any legal responsibility and HIV transmission is to find **evidence**: On the *mens rea* (if the named presumption should amount to intent) or on *every* other relevant aspect. E.g. that sex took at all place, that the

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privacy, can collide with higher levelled public or general goods, and it would have to yield reasonably before them.

[21] A second precondition, namely, that the HIV carrier knows about the risk that his health status means for others if she does not act responsibly, is involved in the general assumption above. According to it, even if additional information on this point (e.g. by GPs), would be everything but wrong, these persons will not be allowed *iuris tantum* to state to have ignored their own infective potential or the transmission ways of HIV (s. negligence below).

[22] Schünemann 1991, 97 ff. Not as negligence but beyond the limit to recklessness could be seen in the case above (fn 20): A person who has (had) intimate contact with other individuals that she knows (or should know or strongly presume) to be HIV infected, and has likewise unprotected sex with other third persons (s. fn 21).

[23] Recklessness (*dolus eventualis*) and intent (*dolus*) would lead in German and Spanish Law to the same criminal consequences, but not in English Law: s R v G and others [2003] 4 All ER 765. Recklessness is in England conceptually very close to gross negligence and both follow to similar results: Cunningham [1957] 3 WLR 76; [1957] 2 All ER 412; Sangha [1988] 2 All ER 385.

For the English Law *mens rea* may be objective - negligence, gross negligence (recklessness) - as to the risks; subjective - intent and foresight - as to the purpose; and then independent of those - strict liability -. The crime definition (*actus reus*) may require any of them. For the German and Spanish Law, with some differences between them with regard to crime definitions and culpability, negligence and intent are part of the same criminal level, and strict liability can only apply to Civil Law.

persons concerned engaged in unprotected sex, that sex (or a HIV infection) happened after the HIV carrier was aware of his health status, that the new HIV infected was not previously informed or that she consented in that unprotected sex, etc[24].

Most essential it is to find evidence on damage *causality* (i.e. to demonstrate beyond any reasonable doubt that a certain infection was transmitted by a certain person)[25], as no legal responsibility can be assigned without proving it. In this sense, if intention - at least as recklessness - could be inferred from certain premises, causality can and will not be presumed.

Reasons for those difficulties to find evidence are the *time* that may elapse until the HIV positive status of the new infected person(s) is determined, due to the long virus latency, as fewer proofs will be disposable after a while, and the *intimacy* in which sexual activities normally happen.

In the absence of enough concrete evidence, only through (indirect) assumptions - or case-related inductive pieces of conviction - it has been possible to open the possibility of criminal punishment[26] or civil liability[27], which is not a very firm or acceptable basis, especially for CrL.

All those grounds exposed explain why a reactive law (here, mainly CrL but also Civil Law) will also face huge application problems, and can only be seldom[28] applied, as long as it does not give up their fundamental and constitutive principles -

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[24] Comp. Chalmers et al. 2002; Bennett et al. 2000.

[25] E.g. through virus similarity it will have to be reasonably excluded that the infection had another source (Dettmeyer 2001, 317; Schünemann 1991, 93 ff).

[26] In the 2003 London landmark case mentioned *infra* (fn 28), virus similarity, two women infected, comparable testimonies, long relationships with the accused person, etc.

[27] A complicated question here is to determine which damages the victim will have to be compensated for (if any, s. below). *A priori* the amount will probably be more important in Spain, because of the ample definition of art. 1902 CC, and less in Germany (§§ 823, 253 I BGB) or England (Fenton (1830) 1 Lew 179 - but Franklin (1883) 15 Cox CC 163; Lamb [1967] 2 QB 981.

[28] UNAIDS 2002; Laskien 1988, 100. In this sense, a recent decision constitutes a leading case in England because, for the first time in 137 years (since 1866), a man was convicted (8 years imprisonment, for grievous bodily harm: Judge Nicholas Philpot, Inner London Crown Court, October 2003), for having intentionally transmitted a sexual disease - here, AIDS. This decision was quashed though by the Court of Appeal on 5th May 2004 and retrial was ordered ([2004] EWCA Crim 1103).
Also in the UK, the High Court in Glasgow convicted another man for recklessly causing injury to another and sentenced him to five years imprisonment (NAT 2004); and so was convicted a woman recently by a court in Cardiff (BBC 2005a). S. Georgiu 1997, in Bennet et al. 2000.

what is not to be expected or tolerated -, for they prevent their undesirable over-dimensioning[29].

The following statements will concentrate on CrL as it has a greater potential to affect personal fundamental rights and its function owns a higher social and political relevance. In this sense, it have to be kept in mind that at least three principles are constitutive for CrL, certainly together with a fourth, more general, one - respect for the background of fundamental rights in which CrL and the whole legal system are immersed -. They are: Minimal intervention, *ultima ratio* (CrL should be the last resource to be used) and *in dubio pro reo* (i.e. it would be preferable to release a guilty person than to convict an innocent). The next pages will try to offer a perspective on how CrL may comprehend reactively a crime or offence based on non-disclosed risky sexual activities of HIV carriers.

3.1.1 Endangering v result offence

For HIV+ persons to practise unsafe sex without disclosure could be an **endangering** offence[30], i.e. there would be no need of harm or damage: It would be enough the proof of carrying out the prohibited action - as dangerous *per se* for the legal good to protect - for the fulfilling of the *actus reus* of the respective crime[31]. In lieu of this it is thinkable to make of HIV infection a **result** criminal offence[32]: It means that a damage to the legal protected good concerned has to occur in order for the action to be prosecutable[33].

The first solution, which as covering more theoretical cases seems to offer a more thorough general health protection, may however cause more trouble than it can solve.

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[29] It should not be forgotten that even a limited applicable CrL (and civil liability) has other functions to comply with (e.g. prevention, control, information and attitude shaping). S. UNAIDS 2002; Chalmers 2002; Mir Puig 1993; Leskien 1988. To a symbolic function of CrL, s. Romeo 2002.

[30] E.g. drug dealing; falsification of official documents; unduly carrying the title or/and acting as a physician. Comp. Gutiérrez Luna 1992, 155; Schünemann 1991, 93-4. These criminal offences grow over-proportionally in our modern so called "risk societies" (comp. Herzog 2003; Prittwitz 2003).

[31] In our case, just the exposure to the HIVirus under the named criminally relevant conditions: To have had as HIV infected person unsafe sex activities without forewarning their sexual partners.

[32] Homicide, rape, robbery, etc.

[33] Here, at least a HIV transmission or infection. For the attribution of criminal responsibility it would not be necessary that it comes to AIDS as the extremely negative consequences of HIV for the concerned person are doubtless to be already deemed as damage: Uncertainty about the HIV development, constrains through medical treatment, psychological and social drawbacks, etc.

Mainly because it might indirectly end in a kind of criminalisation of HIV carriers just because of their condition, what would very probably be counterproductive from the social, psychological and epidemiological sight (s. above). It would also lead to an undesirable expansion of CrL, at the high cost of restricting individual rights, therefore contradicting its own function and principles. Finally, if damage were criminally irrelevant, one of the most essential of the (here) rare evidence elements (the HIV infection) would become unnecessary[34]. And given that most of the situations will not easily allow any other proofs apart from the testimonies of the few persons concerned, this proposal could hence derive into a high degree of arbitrariness and legal insecurity, probably incompatible with an expansive interpretation of the fundamental rights of HIV carriers[35], or else into the inapplicability of CrL because of lack of evidence.

We will probably agree that unsafe sexual activities of HIV infected without disclosure should be prosecutable as risky/dangerous and morally repealing, even before any infection takes place. And that criminalisation would to a great extent depend on "luck" in awaiting a result - as the level of control over the possibility of transmission exercised by the non-discloser is minimal[36]. Nevertheless, the legal, social, psychological and economical disadvantages of an endangering offence in this case would not compensate its potential benefits. Sexual risky activities related to HIV carriers should hence just constitute result crimes, i.e. be prosecutable only if a HIV transmission or infection occurs.

3.1.2 Imputable offence

It is possible, as history and some legislations show, that a HIV infection builds a special offence *per se*[37]. Or it may also happen that this infection is included

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[34] This practical argument, useful for sure, must not be decisive alone, as other crimes belong doubtless to CrL although evidence may not always be available (e.g. rape , especially by the own partner).

[35] STC 140/1986, 11th November; Art. 19 IV GG; Eberbach 1991, 90 ff.

[36] According to Chalmers (2002, 161), exposure can not be seen as an "attempted" transmission also for this reason. He proposes hence two specific criminal offences, one of each type: transmission and exposure. The problem is that the "luck" argument cannot be here easily consistent with any criminal result or *mens rea*. And indeed, if HIV transmission were just a matter of luck, any practical role of CrL might be anyway questioned.

[37] S. for instance, Chalmers 2002.

unspecifically in a more general criminal *actus reus* (transmission of infectious diseases, poisoning, - grievous - bodily harm, manslaughter, etc.). This is by far the most frequent case in the present legal systems[38] and, therefore, the only one considered in this section. The brief analysis below will concentrate on the following three general crimes for reasons of interest and frequency[39], in order to decide which one of them would best fit to the criminalisation of the above mentioned HIV infections: manslaughter[40], even murder[41], or (grievous) bodily harm[42].

If one can broadly define **bodily harm** as any physical (or psychological) damage to an individual's health, it seems logical that the person that transmitted the HIV to another individual can be blamed for at least having caused bodily harm, even if AIDS has not already made its appearance[43].

The most important question will be, if and under what circumstances a person can be charged alternatively with **homicide** (manslaughter or murder)[44]. Concern this issue it is very convincing the analysis of Schünemann, who pleads for a negative answer[45]. A lot of aspects support his argumentation, even if it is true that any solution *a priori* may always be contradicted in the praxis[46]. First of all, the difficult question of proving the killing - excluding any other - intention (*animus necandi*)[47]. Secondly, as it was argued, risky sex and an eventual death result are causally far away: The degree of transmission of HIV is very low, the development to AIDS - if at all -, is slow, and so a possible death, and finally, the use of medical drugs, different individual bodily

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[38] Comp. UNAIDS 2002, 30 ff; Díaz Pita et al. 1997, 166 ff; Mir Puig 1993; Schünemann 1991.

[39] The offence of deliberated transmission of diseases has been seldom applied, as it usually requires for the offender a (more or less high) number of infections for the fulfilment of the criminal *actus reus*.

[40] Art. 138 CP; § 212 StGB; s 2 (3) Homicide Act 1957 - Kennedy (1998) Crim LR (1999) 65; Lamb (1967) 2 All ER 1282 -.

[41] Art. 139 CP; § 211 StGB; s 1 Homicide Act 1957.

[42] Art. 147 ff (specially 149) CP; § 223 I StGB; ss 47, 20, 18 Offences Against the Person Act 1861; R v Clarence (1888) 22 QBD 23, [1886-90] All ER Rep 133.

[43] *Bodily* will be thus be here broad understood, in the sense of fn 33. *Obiter dictum*, no violence is needed to be criminally convicted of bodily injuries: R v Ireland, R v Burstow [1998] AC 147.

[44] BGHSt 36, 1/15ff; Z v Finland (1997) 25 EHRR 371 EctHR, where Z was convicted with manslaughter.

[45] 1991, 97 ff. Comp. BGHSt, 14th March 2003, 2 StR 239/99.

[46] E.g. if a HIV carrier has knowingly often unsafe sex specially with persons having a fragile health, or where efficient medical care for AIDS-ill is not enough guaranteed. Due to a more immediate cause-effect relation (infection-death), HIV infection could build in both cases a criminal basis for homicide.

[47] In case of homicide, the use of the afore mentioned negligence presumption would be doubtful.

reactions to the HIVirus, the progress of medicine, etc. may hinder the death of the victim.

Combining these two arguments, too many external and internal factors are interposed between a possible purpose to kill and its fulfilment which are beyond the control of the potential offender and which therefore cannot guarantee with an acceptable degree of certainty an intended deadly result[48].

To conclude, and as formal argument, the consent of the victim concerning risky sexual activities - which is relevant in sexual activities of HIV carriers to avoid punishment if informed and free - is formally admitted as criminal justification *only* for bodily injuries, but *not* in case of homicide[49].

These arguments could probably prevent the crime from being labelled as homicide, even in case of death after transmission[50]. As much as, for the same reasons, if the victim does not die, they should prevent the crime from being qualified as frustrated or attempted **manslaughter**[51]. Those same arguments hinder *a minori ad maius* in the same way that a HIV infection can be criminally qualified as **murder**.

Consequently, HIV infections that occur as a result of non-disclosed unsafe sexual activities fulfils legally only the crime of (intended or reckless) - grievous - **bodily injuries**.

Within this introductory frame and having all these considerations in mind, we are in a position to try to give an answer to the most relevant cases concerning criminal sexual activities from HIV carriers and their partners.

3.1.3 Third Party notification by HIV carriers to their sexual partners: the cases

Let us remember and develop the statements above on the possible duty of HIV carriers to forewarn their sexual partners:

- On the one hand we may agree - so our assumption - that everyone has enough information on HIV/AIDS to act autonomous and responsibly in this regard. Every

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[48] S. also the "luck-argument" above.

[49] R v Brown [1994] 1 AC 212; § 228 StGB; Art. 155 CP.

[50] S. Chalmers 2002. It can be criminally unacceptable and contrary to legal security to be obliged to wait (a long time) to see if the victim dies to be able to charge the offender with manslaughter.

[51] S. fn 69.

legal capable person should presumably be able to know and decide, according to his fundamental liberty and autonomy, that/when he puts his health or life at risk by engaging in risky sexual activities and/or under which conditions he wishes to do it, so that disclosure in the concrete case is not as essential or necessary as in other contexts.

For this non-disclosure can also be argued the social and psychological negative effects for a HIV carrier to reveal his condition.

- On the other hand we could also give a carefully positive answer to that duty, for everyone is obliged by the principle of *naeminem laedere* (cause no harm), which would prevent individuals from putting others at risk - in this case, by not informing them about their health condition and, nevertheless, engage with them in unsafe sex. Moreover, just trusting on a general information degree on HIV and AIDS and that all people concerned will act correspondingly - so that a duty of disclosure would be redundant - presuppose indirectly a knowledge level, behaviour consequence, freedom and personality strength that may not perform in the praxis as ideally as it should: e.g. by a persuasive HIV carrier or by a sexual partner with a weak character[52]. Finally, it is clear that almost any activity means to assume a certain risk, but it appears also that people act more cautiously the closer (i.e. less general) they perceive the risks - for example, through disclosure in the concrete case[53].

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[52] UNAIDS (2002, 26) reports about women that might not be in a cultural position to impose their views or wishes to their respective male sexual partners. In this cases it will be ethically (and so, legally as well) mandatory for the latter to assume the duty to protect those women they want to have sex with. And probably disclosure would not be enough, but just to have safe sex practices.

A character weak HIV carrier, fearing to lose the intimate relation, was anyway convicted (BBC 2005a).

[53] Even if everyone (analogically regarded) is doubtlessly aware of the risks of taking drugs, driving fast or without helmet or fastened belts, this information does not (always) prevent people from running (unnecessarily) those risks. *However*, people become more cautious (or aware) after having observed the concrete harming consequences of that risk (e.g. after just have seen a car accident people drive more carefully). Comp. Bennett et al. 2000; Adams 1998; fn **Fehler! Textmarke nicht definiert.**.

In our case, a person, before accepting an unsafe sexual relationship, may positively consider running this uncertain risk (not everyone is HIV+ and not every risky sexual activity means a HIV infection). However, after she knows for sure that her possible sexual partner carries the HIV, she will most probably be reluctant to take the now more certain infection risk.

It seems thus unbalanced to blame only the presumable well-informed non-infected persons (unaware in this particular situation though) and to absolve in any case HIV carriers, according to the premise that anyone knows or should know what they do[54].

All this would in principle support to partake the responsibility attribution between those sexual partners concerning the consequences for their sexual activities. To achieve more clearness on this balance, it will be necessary to deepen this analysis.

It could be affirmed that the main reason for disclosure (i.e. for the disclosure duty) would be that the freedom and free development of the personality of HIV carriers find its limit in the same rights - or even, perhaps, higher levelled rights to life and bodily integrity - of their counterparts[55]. So if this is the point, their first obligation will not be to forewarn immediately, but to act responsibly and to protect their partners from risky activities: i.e. for instance to use condoms - despite any rest risk inherent to barrier methods[56] - or to refrain from critical sexual practices. This solution would spare them to reveal their health status, and allow them the feeling of living the most "normal" (here, less constrained) possible sexual life - avoiding at the same time the negative consequences of stigmatisation or social isolation.

As a result and as a rule, a HIV carrier is obliged to have just safe sex (i.e. protected or else, not significantly risky) with her partners or else, to disclose her health status.

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[54] In fact, according to a survey in England, even if 89% of the people agree that individuals are responsible for their own health, 40% mean that there are too many factors outside individual control to hold people responsible for their own health (KF 2004, 3).

[55] Comp. Mason 1999, 273. The fundamental right to autonomy and decision freedom of their sexual partners is compromised without information on that concrete risk. And we may agree that the autonomy of enjoying unsafe sex should legally weigh less than the possible serious damaging results for (alien) legal goods, specially as these can be prevented without renouncing to sexual liberty.

[56] The only 100% safe way to avoid a HIV (sexual) infection is certainly sex abstention (Barba 2004).

It is true that condoms are not always an absolute safe method (just 69% safety, quoted in Chalmers 2002; or probably much more: http://www.cdc.gov/hiv/pubs/facts/condoms.htm, 20.1.2005; http://www.niaid.nih.gov/dmid/stds/condomreport.pdf, 20.1.2005; comp. Bengel 1993), but it offers an acceptable high level of protection, enough to allow HIV carriers to engage responsibly in sexual activities.

The contrary (to poke "precautionarily" on the rest risk of infection despite condom protection) would mean that HIV infected would be obliged in any case to disclose their health condition, with negative consequences for them from the social and psychological point of view, or else, to abstain from sex (a disproportional and, anyway, not enforceable, efficient or feasible preventive measure).

That rest risk should not burden additionally HIV carriers and could be ethically/legally covered by their sexual partners - who are presumable well informed on HIV/AIDS and will be in principle free to choose if, and, in this case, with whom they will have sex and under which safety conditions.

If a HIV infection took place in spite of respecting these rules, she could not be charged with any criminal[57] (or civil) responsibility just for this reason[58]. If she does not respect them, she can be legally charged with the responsibility for the damage caused.

However, the breaking of these rules will not be a immediate step for somebody to be legally responsible. It will be a matter of evidence, as it was shown. Beside a damage result, and mainly concerning CrL, it will have to be a fact beyond any reasonable doubt, at least, that unsafe (included undisclosed) sex took place, that the HIV+ person knew about her condition at that time, and that the damage connects her causally with that unsafe sexual relationship. The following section will show under what circumstances criminal responsibility may and should be achieved[59].

3.1.3.1 HIV carrier engages in unsafe sex without disclosure. Infection happens

As it was seen, it would be right that CrL prohibit and punish unsafe sex practices of HIV carriers without disclosure - leaving apart other legal relevant aspects (s. proof of causality or intention) -, given that:

+ The consent of the victim can be presumed to be invalid - despite the voluntary basis of those sexual activities and the general risk known and involved[60], as it can reasonably be doubted if she would have consented (at least to the sexual risky

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[57] Disclosure (or by protected sex, the general information knowledge) would thus draw the limit line between the criminal offence (bodily injuries) and the criminally tolerated consented bodily injuries: § 228 StGB; Art. 155 CP; Comp. R v Clarence (1888) 22 QBD 23, [1886-90] All ER Rep 133; Hegarty v Shine (1878) 4 LR Ir 288; Collins v Wilcock (1984) 3 All ER 374); UNAIDS 2002, 10.

[58] Erin/Harris 1993. Beyond other moral considerations, such as the duties not to harm oneself (by consenting to have unsafe sex knowingly with HIV+ persons) or others (having as HIV+ unprotected sex, disclosed or not, with healthy people), this can be seen as a balanced solution between the rights to autonomy or self-determination of respectively the HIV carrier and her sexual partner. It can be doubted if autonomy may "clean" both duties not to harm above, but the contrary would ground a far more doubtful criminalisation of both actors (comp. Bennett et al. 2000).

[59] Definitive responses - but not unambiguous, as decisions are and have been very different and probably contradictory so far according to differing situations - are to be expected only at court. Comp. for example in German Courts: BGHSt 36, 1, 4th November 1988; BGHSt 36, 262, 12th October 1989; LG München I AIFO 1987, 648; LG Hechingen AIFO 1988, 220; AG Kempten NJW 1988, 2313, etc.

[60] Erin/Harris 1993; BGHSt 16, 131; in Canada: R v Cuerrier [1996] 141 DLR (4th) 503, [1998] 2 SCR 371; Chalmers 2002 162. It may be necessary to make the fiction of distinguishing between consent to sexual intercourse and to the HIV risk (comp. Clarence), as it seems not to be reasonable to accuse the "offender" of sexual assault or rape (Chalmers 2002, 162) - not even by deceiving (s. below) - in case the consent to sexual intercourse were considered invalid.

activities) in case she had known for sure about the health condition of her sexual partner.

+ The moral and legal judgment of a HIV infected person who is or should be in any case aware of the certainty of his putting other lives in serious risk - and obliged not to do it - would doubtfully be covered by that general information knowledge[61].

+ There would be reasonably acceptable alternatives for HIV infected to undisclosed unsafe sexual practices.

+ Goals and principles of CrL would be compatible with the criminalisation of this refutable attitude.

Consequently, as long as the facts above are proven and considering all criminal guarantees, the offender should be charged here with reckless - grievous - bodily injuries.

3.1.3.2 HIV carrier engages in unsafe sex by deceiving. Infection happens

The moral and legal disapproval of unsafe sex by HIV+ persons will certainly be stronger if he actively deceives, i.e. he cheats or assures to his potential sexual partner that he is not a HIV carrier. This action, which will most probably lead to the other person's lowering her level of precaution, will ease his probable goal: To obtain consent to the risky sexual contact[62]. In other words, the intended misrepresentation increases the level of defenselessness and so the victim's risk of exposure.

As a result, there will probably be much less concerns in generally accepting the intervention of CrL in this situation[63]. For even if every mature, legally competent

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[61] Even more: The fact for a HIV infected to have a sexual partnership during a relative long period of time, also as safe sex, should mean for him a disclosure duty. The ground is practical: The more often the sexual activity, the higher the infection probability. Also because a foreseeable increase in confidence between them can be presumed after a while, what would possibly lead after some time to unsafe sexual activities. As surely no evidence will be available, a proven stable or long sexual relationship could be a useful presumption *iuris tantum* for unsafe sex activities (s. Bennet et al. 2000).

[62] Also in this case, and precisely leaning radically on the knowledge assumption of this report, it could be argued that everyone - not the State or anyone else - is responsible for herself and for her own health, so that this knowledge could even counterbalance any kind of deceit or misrepresentation. This consequent but probably too radical position finds also its theoretical support: "Any responsible person should act as though her respective sexual partner were HIV infected" (Heilmann 1991, 132. Comp. Erin/Harris 1993).

[63] UNAIDS (2002, 10) reaches the following solution: "mere non-disclosure of HIV positive status should not amount to a criminal offence", in case of a significant risk, but "deceit" should, as the sexual partner has been misled into basing choices on wilful misinformation.

person should be supposed to act responsibly or at least to be able to decide when she puts herself at risk, this cannot correlate with preventing others from being criminally responsible if they (even more clearly as in the last section) recklessly[64] jeopardise other persons' life or health. Also, because her consent would be invalid in this circumstance due to her previous instrumentalisation[65]. Finally, the goals of deceit so as to obtain risky sex with a non-infected person cannot balance the possible health damage, as sex could be obtained at a much lower level of risk.

The main problem in this regard will be however to prove and differentiate the latest two criminal behaviours (non-disclosure and deceit) in the praxis[66]. Even if we agree that deceit deserves a more severe criminal treatment than non-disclosure of the real risk situation, it will not be easy to find (any) evidence which definitively proves if we face the one or the other case (i.e., to prove unequivocally deceit) or even any of them, provided the intimacy in which these contacts take place.

It might hence be considered sensible and acceptable for practical reasons to assimilate both cases and to adopt a common criminal position *a priori* for them (if ever enough evidence on unsafe sexual activities, non-disclosure, causality and damage exists).

Certainly, if this deceit or misrepresentation could be proven, it will have to be taken into account by judges or courts, and deserve a more severe punishment. Otherwise - following the principle *in dubio pro reo* - this case will also have to be categorised at most as reckless - grievous - bodily injuries (s. above).

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[64] If culpability (*mens rea*) is according to the broad knowledge on HIV/AIDS presumed, at least at the level of 'recklessness', in case of deceit this presumption may be consolidated as a *de facto iuris et de iure*. This *dolus eventualis* could even amount to 'intent', given the higher level of criminal reprobation, although the purpose of this deceit was supposedly just to obtain (unsafe) sex and not to cause any harm.

[65] Comp. Kennedy/Grubb 2000, 672. By R v Cuerrier [1998] 2 SCR 371 (Can Sup Ct), as no infection took place, this invalid consent was probably seen as the only way that led to criminal responsibility. The HIV+ offender had unsafe sex by deceiving with two victims. Their consent was considered invalid because of deceit, so he was convicted with sexual assault - social-politically perhaps a right decision, but a doubtful one with legal-criminal arguments. MacLachlin J: "*The Courts should not broaden the criminal law to catch conducts that society generally views as non-criminal. If it has to be done, Parliament should do it*"; "*Conduct like that in the case at bar shocks the conscience and should permit of a criminal remedy*"; "*I conclude that the common law should be changed to permit deceit about sexually transmitted disease that induces consent to be treated as fraud vitiating consent*".

[66] Which would be decisive if they should lead to different legal consequences (s. UNAIDS 2002, 10).

3.1.3.3 HIV carrier intends to transmit the HIV through unsafe sex practices. Infection happens

The last case to analyse would be the intended and succeeded transmission of the HIV, i.e. when the attained purpose of the HIV carrier (most probably with deceit or without disclosure) is directly at least to harm her partner's health[67].

It is true that the level of criminal disapproval of this HIV+ is even higher than that of the situations above. The practical point of view is, however, the same. It will not always be possible to implement this subjective feature into corresponding criminal categories, given that very few indices or evidence, if any, will allow to back up that intention[68]. If there were enough evidence though, the criminal punishment would have to be the most severe of all analysed cases.

One mentioned question however is that even if a subjective harming intention were clear, reality in form of a long and unstable causality chain would contradict this purpose - certainly not at the level of an unsuitable attempt[69] -, and this could hinder its criminalisation. There is *re propria* no guarantee - in fact, as it was seen, it is rather difficult - that an infection will take place and that it, if at all, amounts to AIDS. Criminalisation would be in this sense more complicated still if the harming purpose went any further (death, s. *supra*). Due to this lack of control of the criminal result by the offender it might be doubted to what extent "intent" as criminal category might be possible.

Hence it seems reasonable, now for other practical reasons, to propose a similar solution *iuris tantum* for all these cases. With the necessary proofs but without any other relevant evidence, this would probably be as well *recklessness - grievously - bodily injuries* resulting from unsafe (or non-disclosed) sexual activities of HIV carriers. The concrete situation (and further evidence) can precise afterwards the

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[67] For instance one of the most recent relevant cases (Gutiérrez 2004; Aker 2004; EP/AFP 2004; comp. Smith 1994).

[68] Intent (or eventually an equivalent degree of recklessness) will have to be mostly inferred from indices, as far as those also can be proven: e.g. through the frequency and the form of sexual contacts, the degree of deceit, the victim circumstances, etc. The assessment of those indices may be only valid for the concrete case.

[69] Factual impossibility for the action to fulfil a criminal *actus reus*, which might not be criminally pursued. Comp. Art. 16 CP; STS II 1388/1997, 10th November; 1018/1996, 16th December; STC 70/1985, 31st May; Mir Puig 2001; Sola Reche 1996. §§ 22, 23 III StGB; RGSt 33, 321; BGH, NJW 1995, 2176.

degree of the offender's reprobation and culpability and take this into account for the determination of punishment.
All this shows how far away legal theory and its practical transfer can be when applying consequently precisely the most essential legal principles.

3.1.4 Result

If we take a general level of knowledge on HIV/AIDS for granted, as it is the case in Spain, Germany and England, this will allow Law just a minimum intervention frame, i.e. to react only if HIV carriers do not act responsibly, which means a maximal respect for their individual fundamental rights. No public enforceable preventive measure will be needed (or lawful), and only a minimum of preventive measures will have to be observed by HIV+ persons. Moreover, such respectful attitude towards the concerned individuals will assure a better control of the negative social, psychological, economical, etc. consequences of HIV/AIDS, and therefore, better epidemiological results.
As unique preventive measures, HIV carriers will be legally obliged to disclose their health condition to their sexual partners - as soon as they know or should have known about it - unless they constrain themselves to so-called safe sex. Under the observance of these rules no criminal offence can be committed or civil compensation for damages can be settled. If they do not observe those rules, especially CrL but also Civil Law will react, i.e. only after irresponsible acting and not before.
However, irresponsible acting has not often found a legal answer as a consequence of the respect owed to their basic legal principles and, in any case, to the fundamental rights of individuals, that could be easily affected by legal action. The background of this partial inactivity has practical reasons, mainly the lack of evidence on the relevant aspects and a doubtful causality relation between action (omission) and harm.
With regard to criminal responsibility, and in order for HIV carriers to be prosecuted, it should be its precondition that a damaging, criminally relevant result (at least a HIV infection) has occurred to the victim after not having followed any of the options above. In this case, and for many factual grounds, the most probable offence should be - grievous - bodily injuries, unless other evidence on factors like deceit or intent may be found.

With regard to damage compensation, civil liability may also be due if damage happens to be causally sufficiently related to the unsafe sexual activity by HIV+ persons.

Finally, as the assumed general knowledge above should, if possible, protect the victims and not their offenders, the accountability of HIV infected that act irresponsibly will not be eliminated but even stressed with this knowledge, disregarding *de facto* offenders' negligence in case of HIV infection, and presuming their (conditioned) intention.

3.2 Third party notification by physicians to sexual partners of HIV carriers

Third party notification of the own health status concerns, if at all, primarily only HIV carriers. It may happen, however, that other individuals may be allowed (or even obliged) to disclose this condition to those persons who are being jeopardised by those HIV carriers whom they have undisclosed or unsafe sex with. This is possible only if they are informed about the health condition of the HIV carriers and about their jeopardising undisclosed activities. Normally the GPs (general practitioners, physicians) are the only suitable individuals allowed (or obliged) to that notification: Either because their patients revealed this previously - it is a patient's duty to inform their physician on any relevant aspect of their health, so that these are able to comply with their job[70] - or due to a blood test for HIV antibodies[71].

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[70] Heberer/Mößbauer 2004, 138; Dettmeyer 2001, 85.

[71] A test that cannot be carried out without the patient's consent. Although such measure could have a preventive value for public health, no one can be forced to make an AIDS analysis, according to the principle *noli me tangere*, even in case of positive indices (Rivero 2000, 212). It would be against the patient's bodily integrity (STS 18th May 1994, RA 4042), a breach of his autonomy or freedom, equivalent to an arrest (Decision of the ECommHR of 13th December 1979) and, in general, a severe violation of his personality rights (Art. 7 ECHR; Dettmeyer 2001, 53 ff; LG Köln-MedR 1995, 409), which could thus lead to compensation (§§ 823, 253 I BGB; art. 1902 ff CC). S. BVerfGE 72, 170 ff; 65, 41 ff; BGH NJW 2005, 287 ff; Canada AIDS Society v. Ontario (1995), OR (3d) 388 (Gen. Div), aff'd (1996), 31 OR (3d) 798 (CA), leave to appeal to SCC refused 8th May 1997; Kennedy/Grubb 2000, 592 ff; Mason 1999, 271 ff; DBt 1988, 174-5.

For a slight different, more polemic position, see GMC 1997. Addressed to GPs, it reads:

4. You must obtain consent from patients before testing for a serious communicable disease, except in the rare circumstances described in paragraph … 9 …below. … Some conditions, such as HIV, have serious social and financial, as well as medical implications. In such cases, you must make sure that

The main question as background of this second part, subsidiary third party notification, concerns the duty of confidentiality of health personal, specially physicians: If and when physicians are allowed (or obliged) to reveal to certain third persons the health status of their HIV+ patients.

3.2.1 Duty of confidentiality. Medical duty of confidentiality

The duty of confidentiality, which is related to and obliges some professions and their professionals, is rooted in the free development of everyone's personality - in this case, their clients'. More exactly, it roots in two of the most important aspects of such freedom: Privacy and informational autonomy[72]. Such essential duty is thus constitutionally protected, but not in every circumstance - and, certainly, not beyond the own autonomy of the concerned person, as any individual may disclose himself (s. above) or consent to the disclosure of any intimate aspect of his private sphere[73]. The duty of confidentiality obliges those professionals whose activities are precisely based in trust relations with their clients, and in important aspects of these clients' privacy. It involves any intimate information they were revealed, or that was known or found out in connection with those professional activities. This pivotal duty is more particularly sanctioned and protected, among others, by CrL[74].

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the patient is given appropriate information about the implications of the test, and appropriate time to consider and discuss them.

9. If the patient refuses testing (...) you should reconsider the severity of risk to yourself or another injured health care worker, or to others. You should not arrange testing against the patient's wishes or without consent other than in exceptional circumstances, for example, where you have good reasons to believe that the patient may have a condition such as HIV for which prophylactic treatment is available. In such cases, you may test an existing sample, taken for other purposes, but you should consult an experienced colleague first. It is possible that a decision to test an existing blood without consent could be challenged in the courts, or be the subject of a complaint to your employer or the GMC. You must therefore be prepared to justify your decision.

[72] Arts. 10.1, 18.1, 20.1, 24.2 CE; Arts. 1.1. and 2.1. GG; Art. 8 (1) ECHR; BVerfGE 52, 131, 166 ff; Z v Finland (1997) 25 EHRR 371 (ECtHR). Comp. BVerfG Resolution of 8th March 1972.

[73] BVerfGE 15th December 1983; R v Department of Health ex parte Source Information Ltd. (1999) 49 BMLR 41; A-G v Guardian Newspapers (No 2) [1990] 1 AC 109 [1998] 3 All ER 545 at 658; Megarry V-C in Malone v Comr of Police of the Metropolis (No 2) [1979] 2 All ER 620 at 645 [1979] Ch 344 at 375.

[74] Mainly focusing on physicians and other health professionals, s. arts. 199.2, 278 ff, 466-7 CP; § 203 I 1 (infringement of private secrets); §53 I 3 StPO (medical right to refuse to give evidence). The infringement of the duty of confidentiality builds no general offence in England, but in some specific acts: e.g. ss 33 and 41 (5) Human Fertilisation and Embryology Act 1990. Comp. R v Dept. of Health, ex pte Source Informatics [2001] QB 424, [2000] 2 WLR 940.

If we take health professionals (here, especially physicians) and patients as example, the limit of their duty of non-disclosure (or of the patient's right to privacy) is or can be the "right"[75] for them - or even duty - to breach their confidentiality obligation with their patients when it might be due.

3.2.2 Breaching the medical duty of confidentiality

This is a logical but very controversial statement at the same time, as any exception to the medical confidentiality duty is regarded with suspicion, mostly on the basis of slippery-slope argumentations. Nevertheless, as it is well known, there is no absolute or unlimited right, i.e. any right (or exercise of rights) has its boundaries, provided that they are justifiable in the name of higher levelled goods and reasonableness. For instance, by right exercises that undermine their own value or relevance[76]. Or in case of a superior duty of public interest protection, which might be exactly established by statute[77] or not, e.g. in case of emergency[78]. In our example, and concerning this last circumstance, the rule must be at any rate that disclosure has an exceptional character, always in proportion to the real infection risk, which must thus amount here to **danger**[79], i.e. a serious and immediate threat for the health or life of sexual partners of HIV carriers[80].

In fact, in case of physicians, this duty is part of their Hippocratic oath: "Whatsoever things I see or hear concerning the life of men, in my attendance on the sick or even apart therefrom, which ought not to be noised abroad, I will keep silence thereon, counting such things to be as sacred secrets". And it is included in the professional regulations of all health practitioners (e.g. § 9 MBO-Ä; GMC 2004, pr 9. Art. 20.1 d) CE; SSTS 4th April 2001; 2nd July 1991; any of the non-centralised medical deontology codes in Spain).

Finally, confidentiality is also protected by Civil (Contract) Law - § 241 II BGB; art. 1258 CC; W v Edgell [1990] Ch 359, 2 WLR 471; Stephens v Avery [1988] Ch 449, 2 WLR 1280. (Heberer/Mößbauer 2004, 138; comp. Deutsch 2003, 311).

[75] Or perhaps more accurate, legal justification.

[76] SSTC 207/1996, 16th December; 181/1990, 15th November; STS 16th July 1997. Comp. Art. 19 II GG.

[77] Ss 23 (2); 24 (6) Health Act 1999; NHS (Venereal Diseases) Regulations 1974; art. 9 L 41/2004; LOMESP; ISchG.

[78] § 34 StGB; Art. 20.5 CP.

[79] Gómez Pavón 1997, 138. Comp. Heilmann 1991, 126; Eberbach 1986, 33; MedR 1983, 29.

[80] Comp. Eberbach 1986, 33; also, in this case, § 9 II MBO-Ä; Heberer/Mößbauer 2004, 139; Webster, 1981, 161; Mason, 1999, 506. T*o justify disclosure, the risk must be 'real' rather than fancyful*". W v Egdell [1990] Ch 359, [1989] 1 All ER 1089; [1990] 1 All ER 835, (1989) 4 BMLR 96 (CA), Bingham LJ at 853. All ER 1089 at 1135, per Scott J: "*I accept [that the conclusion that the weight of public interest prevails over the private right to confidence] places W and persons like him in a position in which the*

In order to call this situation "danger" (at least, to justify disclosure) the knowledge of the GP just about sporadic unprotected and undisclosed sexual relations of her patient might not be enough. The reason could be that his privacy and freedom right would be directly affected, the mentioned negative psychological and social consequences, together with the exceptional character of medical forewarning, and that HIV infection risk is statistically not high, even considering the mentioned possible disadvantages of a HIV transmission[81]. However, the health condition disclosure to the respective sexual partner (or an exclusive restriction to safe sex) should be in these cases strongly recommended by the GP to the HIV+ patient.

Life and health may thus have to yield partially before privacy unless they are being *really* seriously and immediately threatened by (unsafe) sexual activities of HIV carriers. To justify a breach of confidentiality (and much more a duty to disclose, if necessary, criminally sanctioned as "failure to help"[82]) it will probably be determinant a certain frequency or stability in the (presumably unsafe) sexual relationship or other exceptional circumstances[83].

It can be hence possible that the right of privacy of HIV carriers (or the duty of medical confidentiality before) might be exceptionally be broken, even if the confidentiality duty in HIV/AIDS-cases is paramount, for any information concerning HIV or AIDS is particularly sensitive given its potential for stigmatising those

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duty of confidence owed by their psychiatrists is less extensive than the duty that would be owed by their psychiatrists to other members of the public."

Comp. in US American Common Law: Tarasoff v Regents of the University of California 529 P 2d 55 (Cal, 1974); on appeal 551 P 2d 334 (Cal, 1976); USA v Chase, US Court of Appeals for the ninth circuit 22nd August 2003.

[81] The general knowledge assumption could partially support this argument as well.

[82] According to German jurisprudence (BGHSt 6, 147; OLG Frankfurt aM 5th October 1999, 8 U 67/99), the right or justification to disclose amounts to a duty if the sexual partner is also a patient of the same physician, because the physician would also be a guarantor of his health (comp. Eberbach 1986, 37). A controvert distinction (s. also OLG Munich 18th December 1997 - 1 U 5625/95), as it could be assumed that the criminal justification of emergency would not be voluntary but compulsory (Lilie 1983, 314). In practice, the position of the BGHSt may not bear many fruits, as the disclosure right or duty of GPs would not diminish if the other known jeopardised person were not her patient. I.e. this guarantor position (e.g. by any informed physician) might be derived from the general duty to avoid harm (Hunter v Mann [1974] 1 QB 767; Tarasoff, above) or to provide help (§ 323c StGB; art. 195, specially 196 CP - ATS 7th May 1999).

[83] S. fn 61. Circumstances such as previous health weakness, and those of fn 52.

infected[84]. Nonetheless, the legal protected goods that counterbalance confidentiality in such a special situation, health and life of sexual partners of HIV carriers being seriously jeopardised by these - that are therefore one of its limits -, have probably a superior weight before Law.

3.2.3 Medical duty of confidentiality and third party notification in case of HIV/AIDS: How to act

Taking all this into account, and also the fact that it will not always be easy for the GP to know how to manage this concrete delicate case according to the Law, it is essential for him to avoid the conflict of legal goods as much as possible: I.e. to serve both medical duties (confidentiality and life protection of third persons) as long as feasible. Hence, in order to postpone *ad maximum* to make a choice, and to prevent any arbitrariness, it would be better for him to try first to persuade[85] his patient to forewarn her sexual partners herself about her health status, even at the cost of the loss of her social relationship - or, alternatively, to constrain only to protected and safe sexual practices -. If, and only if the patient still rejects to forewarn her endangered sexual partner(s), and even if she prohibits her GP to do it himself, he could be allowed (or obliged, according to the circumstances) to breach his confidentiality duty. It is recommended in any case that the patient be informed of this breach, and it is obligatory that disclosure only concerns the persons directly affected by that HIV infection danger. At any rate, this breach will have to be understood restrictively, as a too broad comprehension of this exception could arbitrarily undermine the essential rule of confidentiality.

So the General Medical Council (2004) in this regard:

"27. Disclosure of personal information without consent may be justified in the public interest where failure to do so may expose the patient or others to risk of death or serious harm. Where the patient or others are exposed to a risk so serious that it outweighs the patient's privacy interest, you should seek consent to disclosure where

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[84] Kennedy/Grubb 2000, 1101; X v Y [1988] 2 All ER 649. Comp. Dettmeyer 2001, 85; UNAIDS 2002, etc. *Obiter dicta*, this high protection of privacy means also in this case the following: If laboratories have to notify to the public health authorities that a donor's blood tested positive for HIV, they will have to do it anonymously - if there is no consent -, and only for statistical (epidemiological) purposes (Deutsch 2003, 316; Heberer 2001, 311).

[85] Voluntariness and respect should bring the most positive outcomes, as it was seen.

practicable. If it is not practicable to seek consent, you should disclose information promptly to an appropriate person or authority. You should generally inform the patient before disclosing the information. If you seek consent and the patient withholds it, you should consider the reasons for this, if any are provided by the patient. If you remain of the view that disclosure is necessary to protect a third party from death or serious harm, you should disclose information promptly to an appropriate person or authority. Such situations arise, for example, where a disclosure may assist in the prevention, detection or prosecution of a serious crime, especially crimes against the person, such as abuse of children".

Or, more specifically, in case of HIV/AIDS: GMC (1997):

"22: You may disclose information (…) to a known sexual contact with HIV where you have reason to think that the patient has not informed the person and cannot be persuaded to do so. In such circumstances, you should tell the patient before you make the disclosure and you must be prepared to justify such a decision to disclose information.

23: You must not disclose information to others, for example relatives, who have not been, or are not, at risk of infection".

3.2.4 Duty of confidentiality and other health professions

As far as other health professionals under the responsibility of GPs are concerned, they are certainly likewise compelled to keep confidentiality. However, they should not be obliged to breach that duty. As for the legal justification to be allowed to, they should better stay on the most safe side of Law and inform a physician of the given emergency situation, so that she, if deemed necessary, proceeds to forewarn, as shown above. Only under very exceptional circumstances could they be allowed to disclose as well[86].

3.2.5 Result

Third party notification also concerns health personnel (mostly only physicians) if they know who is being jeopardised by unsafe and non-disclosed sexual relations with their HIV carrier patients. As long as they are obliged to keep a duty of confidentiality - which in HIV/AIDS cases for many reasons is paramount - the risk to which such

[86] RCN 2003, 10 ff. Comp. W v Egdell [1990] 1 All ER 835; § 203 III StGB.

persons are exposed must be significantly high (i.e. amount to danger) and the situation therefore seriously threatens higher levelled goods, such as those person's health and life, to allow disclosure. Forewarning will have to be constrained to those directly affected and should happen only after prior patient's knowledge about this disclosure, in case that he rejects to inform his endangered sexual partners by himself. This legal justification of the breach of confidentiality could amount under certain circumstances to a duty to inform those in most immediate danger, given the essential goods involved.

4 Synoptic commentary

The HIV and the AIDS pandemic have challenged our globalised societies to unknown limits so far, and they still do. Because of them, Medicine, Law, Ethics, Sociology, Psychology, Economy, etc. as much as interpersonal relations have been confronted with questions that have radically changed many of their basements in a way that even at present is far from being settled. In this regard it is important to fix a double aim: To contain the virus spreading and thus the main negative consequences of HIV/AIDS, and to find an optimal basement settlement for all of those fields.

A promising and successful strategy for that double goal appears to be a maximum expansion of general information and knowledge on both virus and disease. This strategy, that has been progressively followed by most countries nowadays, roots in the fact of its possibility (the infection ways are known, also that despite all there is not any definitive cure of that lethal illness yet) and of its proven effectiveness, and relies on and promotes individual autonomy and responsibility.

Apart from the respectful way to treat individuals, the additional advantage of a widespread knowledge on HIV/AIDS is that it prevents and has prevented legal action from staying or falling into the first usual temptations in case of fear and insecurity: Its expansion towards a disproportional repression at the cost of individual liberties. The result of that widespread knowledge on HIV/AIDS and an individual respectful Law is and was that it has permitted and supported the actual liberal development of our societies on the way to more individual autonomy, and the possibility for anyone, beyond paternalism, to take real responsibility for their actions. Law and Society progressively abandon themselves to their capable and well-informed persons, as long as they are given the means to be able to act responsibly. Individuals, and not Law, have the initiative. No preventive restriction of individual rights and freedoms of HIV

carriers is thus allowed. HIV+ persons have just to observe a minimum of (voluntary, as legally unenforceable) prophylactic measures in order to protect directly the life and the health of others.
Only if this confidence is abused, i.e. if individuals do not assume the original responsibility they have a right and duty to, Law will then re-act in the name of all those affected or endangered and of the whole society. Under this reactive Law just those irresponsible abusers are obliged to respond and to carry the consequences of their actions.

This is however only theory so far, unfortunately quite often not too close to practical reality. In two different senses at least. *On the one hand*, the problem with such individual (case) oriented and rights respectful micromalistic view is that it is more difficult to establish general legal rules to be followed, i.e. to indicate *a priori* what and when something would be legally right or wrong and under what circumstances. Such legal attitude, aiming at serving justice, equality and freedom, may therefore, nevertheless, hinder legal security and avoid an accurate orientation on the right acting. A difficulty that may increase if we consider different legal systems or traditions, i.e. if we try that certain statements have a broader scope of application.
To overcome this problem and in order to offer some necessary general pattern orientation, this report has tried to organise the general *status quo* of the English, German and Spanish Law (and international criteria) concerning the disclosure of HIV carriers' health condition. I.e., to point out and lean on the most relevant applicable principles and rules, mainly, reasonability/proportionality, individual fundamental rights and freedoms, and the priority of collective interests. To solve a particular conflict it would be necessary before deciding to weigh all of them according to the respective factual circumstances to consider (damage probability, concerned goods, causality, evidence, etc.).
On the other hand, legal reaction against irresponsible acting can not frequently be implemented. The named well-established and essential principles (additionally, for CrL minimal intervention, innocence presumption and *ultima ratio*) will often not allow legal reaction if - as a rule in the practical reality of these concrete cases - solid evidence and, specially, a firm logical causal relation between action and damage are missing.
This can leave many (however, rare) freedom abusing acts without legal answer.

In this situation, an often inapplicable Law can lead to any of the following conclusions: Either should emerge a more repressive Law, in the name of security, that gives up (partially) some of its traditional principles. Or, on the contrary, the information strategy and of individuals' support and respect should be strengthened even more.

For the first option would not solve the present problem and probably cause other additional ones, it should be discarded (as it has been almost everywhere), and assumed the named little inconvenience of a compromised legal reaction when it were due. As, at any rate, the second conclusion has already shown its effectiveness as much as it allows a progressive reduction of the dependence of (very often, inefficient) Law to solve social problems. This will precisely reinforce the individual autonomy circle started. In this sense, if Law is necessary only when conflicts cannot be (peacefully) solved in another way, and if it is true that Law as a chain becomes more and more indispensable, the more it is used as remedy to solve conflicts, the promotion of other factors (e.g. autonomy, individual responsibility) will indirectly guarantee a progressively more limited dependence from Law, and support a different and more effective conflict solution framework.

Despite the mentioned limitations and considerations, the presence of Law could be justified though, as long as it does not betray itself, for it complies additionally with other functions: Prevention through punishment-persuasion, determination of the respective ethical/legal acceptance level, behaviour shape and orientation, etc.

Law is thus obliged - at least formally - to play a guardian role and to give theoretically reactive security vis-à-vis irresponsible acting: To protect indirectly third persons involved in (unsafe) sexual relationships through the punishment of irresponsible HIV carriers. In this case, and concerning third party notification, Law may look as follows:

- It is assumed *iuris tantum* that everyone is informed when they put their life or the life of others at risk with regard to HIV/AIDS. In spite of this knowledge, HIV carriers are the main individuals charged with the obligation of acting responsibly, as they are aware of their concrete jeopardising position for others and (as anyone else) not allowed to cause harm.

Therefore, HIV infected have to reveal their health condition to their sexual partners if they want to engage in risky sexual activities, or to practise only safe sex. It seems reasonable that the general knowledge in society about HIV/AIDS do not play a

decisive role against the victims, but mainly against wrongdoers. This knowledge can not justify endangering attitudes of HIV carriers - in case they could argue that it concerns also the victims to treat every sexual partner as potential HIV+. On the contrary, it should take away the possibility of any kind of negligent HIV infections by HIV carriers - in case they could argue that they ignored either HIV risks or its ways of transmission.

Concerning CrL in particular, criminal responsibility should be only assigned if a forbidden result or *real* damage (here at least, a HIV infection) has taken place. If this happens as a consequence of proven risky sexual activities without protection and/or disclosure, those infectors will be deemed to have harmed at least recklessly the victim's physical or psychical health. This solution should prevail unless other proven circumstances (deceit, intent, etc.) allow more severity with regard to legal qualification.

The crime to charge those irresponsible HIV infectors with should be, with rare exceptions: *(grievous) bodily injuries*, irrespective if the victim finally dies, or if he does not develop the disease in the end, given the fact of a long and unstable causality of HIV to produce AIDS or any other result (especially, death).

Concerning Civil Law, any victim can complain before a court in order to obtain compensation for any proven damage coming from HIV carriers' irresponsible acting. The respective scope of the damage to compensate, however, may differ between the given legislations.

- The obligation to forewarn sexual partners of HIV+ might subsidiarily affect also those involved in the patient-medical relation (their treating health personnel, primarily only physicians), as far as they know about the health status of their HIV infected patients, about their unsafe and undisclosed sexual activities and about their concrete sexual partners. Only in case of danger to the latter would it be proportional that physicians be exceptionally allowed (or, perhaps, even obliged) to breach their duty of confidentiality and reveal the health status of their patients to their potential victims, and just to them. Physicians have to try previously to persuade HIV carriers to disclose by themselves their health condition to their sexual partners - or, occasionally, to constrain to safe sex. If this fails, or if they even prohibit their physician to do so, any GP might be allowed (or, under some specially dangerous circumstances, obliged) to disclose his patient's health condition to the victim after an accurate weighing of the goods concerned. He should first inform that patient about his purpose of disclosure.

This breach is to be understood very restrictively, in order not to undermine the capital duty of medical confidentiality.

5 Abbreviations

A	*Auto* - Ruling (court) (E)
AIDS	Acquired Immunodeficiency Syndrome
BÄK	*Bundesärztekammer* - Federal Medical Council (Dt)
BGB	*Bürgerliches Gesetzbuch* - Civil Code (Dt)
BGH	*Bundesgerichtshof* - Federal Supreme Court of Justice (Dt)
BVerfG	*Bundesverfassungsgericht* - Constitutional Court (Dt)
BVerfGE	*Entscheidung des BVerfG* - Decision of the Constitutional Court (Dt)
CA	*Comunidad Autónoma (CCAA, pl.*) - Autonomous Community/ies or Region(s) (E)
CC	*Código Civil* - Civil Code (E)
CCESVS	*Comité Consultatif d'Éthique pour les Sciences de la Vie et de la Santé* - National Consultative Ethics Committee for Health and Life Sciences (France)
CDC	Center for Disease Control and Prevention (US)
CE	*Constitución Española* - Constitution (E)
CFR	Council on Foreign Relations (USA)
CGPJ	*Consejo General del Poder Judicial* - General Council of the Judiciary Power (E)
CH	Switzerland
CoE	Council of Europe
Com	Communication (European Commission)
comp.	compare
CP	*Código Penal* - Criminal Code (E)
CrL	Criminal Law
D	Directive (EU)
DASPL	*Deutsche AIDS-Stiftung "Positiv leben"*- German AIDS Foundation "Live Positive"
DBt	*Deutscher Bundestag* - German House of Commons
Dt	Germany; German
E	Spain; Spanish
e.g.	*exempli gratia* - for example (lat)
ECHR	European Convention on Human Rights (CoE)
ECHRB	European Convention on Human Rights and Biomedicine (CoE)
ECommHR	European Commission on Human Rights (CoE) - now obsolete, since 1998 functions assumed by ECtHR
ECtHR	European Court of Human Rights (CoE)

EMEA	European Agency for the Evaluation of Medicinal Products - Evaluation of Medicines for Human Use (EU)
EU	European Union
FDA	Food and Drug Administration (USA)
ff	and the following (pages; articles/sections)
fn	footnote
G	*Gesetz* - Act, Law (Dt)
GG	*Grundgesetz* - Constitution (Dt)
GMC	General Medical Council (Engl)
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HRA	Human Rights Act 1998 (Engl)
i.e.	*id est* - that is (lat)
ISchG	*Infektionsschutzgesetz: Gesetz zur Verhütung und Bekämpfung von Infektionskrankheiten beim Menschen, 20th July 2000* - Protection Against Infections Act (Dt)
J	Justice; Judge
L	*Ley* - Act, Law (E)
LG	*Landesgericht* - Regional Court (Dt)
LGS	*Ley 14/1986 General de Sanidad, 25th April* - General Act of the National Health Service (E)
LJ	Lord Justice; Judge
LO	*Ley Orgánica* - Organic Act, Act with constitutional rang (needs absolute majority in Parliament) (E)
MBO-Ä	*Musterberufsordnung für Ärzte* - Professional regulations for medical practitioners (Dt)
MedR	*Medizinrecht*
MMWR	Morbidity and Mortality Weekly Report
MSC	*Ministerio de Sanidad y Consumo* - Ministry of Health and Consume (E)
NAT	National AIDS Trust (UK)
NCB	Nuffield Council on Bioethics
NJW	*Neue Juristische Wochenschrift*
OECD	Organisation for Economic Cooperation and Development
OLG	*Oberlandesgericht* - Higher Regional Court (Dt)
Op.	Opinion (EU)

OVG	*Oberverwaltungsgericht* - Higher Administrative Court (Dt)
p.	page
PEI	*Paul-Ehrlich-Institut* - Paul Ehrlich Institute (Dt)
PHCDA	Public Health (Control of Disease) Act 1984 (Eng)
PHS	Public Health Service (USA)
RA	*Repertorio de Jurisprudencia Aranzadi* - Reference number of the Collection of Law Decisions Aranzadi (E)
RCN	Royal College of Nursing
RD	*Real Decreto* - Royal Decree (E)
RG	*Reichsgericht* - Imperial Court (Former German Supreme Court of Justice)
s	section
s.	see
SCMPMD	Scientific Committee on Medicinal Products and Medical Devices (EU)
S(S)TC	*Sentencia(s) del Tribunal Constitucional* - Decision(s) of the Constitutional Court (E)
StGB	*Strafgesetzbuch* - Criminal Code (Dt)
StPO	*Strafprozessordnung* - Code of Criminal Procedure (Dt)
S(S)TS	*Sentencia(s) del Tribunal Supremo* - Decision(s) of the Supreme Court of Justice (E)
TC	*Tribunal Constitucional* - Constitutional Court (E)
TS	*Tribunal Supremo* - Supreme Court of Justice (E)
UK	United Kingdom
UN(O)	United Nations (Organisation)
US(A)	United States (of America)
WHO	World Health Organisation

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