

Forensic Considerations of HIV Infected and Those at Risk

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Abstract: While HIV infection is considered protected information in most parts of the world, it is clear that if a health care provider knows, that the patient is infected or is likely to be infected, then either the patient or those responsible for making their medical decisions must be informed of the infection or likelihood of infection. If not, the liability exposure of the health care provider, like the virus itself, will spread to more and more people. It must be remembered that despite the existence of a confidential patient-physician relationship, a health care provider has a duty to warn a clearly identifiable third party of possible serious harm. This reliance suggests that states may eventually extend provider liability to "significant others" and individuals with whom the provider knows, or has reason to believe, the infected individual is engaged in activity which may spread this virus. The focus by the courts reinforces the need for health care providers to stay current with local reporting requirements and their legal obligations.

Key words: HIV infection, AIDS, HIV prevalence, HIV spread, right to know

INTRODUCTION

In most parts of the world, HIV infections occur through injecting drugs with contaminated equipment, unprotected sex between men and unsafe commercial sex. The notion that those epidemics are concerned to specific populations is fanciful, however. Most injecting drug users are young and many are sexually active, risking double exposure to the virus. In some countries, particularly in Asia and Eastern Europe, a significant share of sex workers also injects drugs. Most male clients of sex workers have other sexual partners, including wives and steady girlfriends. In every region, a sizeable proportion of men who have sex with men, also have sex with women. Accordingly, no aspect of the AIDS pandemic is an island unto itself. As AIDS epidemics become more firmly established, more and more young population is becoming infected.

Global summary of the AIDS epidemic December 2004: According to the available information, number of people living with HIV in 2004 was 39.4 million of which 37.2 million were adults, 17.6 million women and 2.2 million children under 15 years of age. People newly infected with HIV in 2004 amounted to 4.9 million whereas AIDS deaths reported in 2004 were 3.1 million of which adults accounted for 2.6 million and the children under 15 years were 510 000^[1].

Asian scenario: National HIV infection levels reported in Asia are low when compared with some other continents, notably Africa. But the populations of many Asian nations are so large that even low national HIV prevalence means large numbers of people are living

with HIV. Asia is not just vast but diverse and HIV epidemics in the region share that diversity, with the nature, pace and severity of epidemics differing across the region. Overall, Asian countries can be divided into several categories according to the epidemics they are experiencing. While some countries were hit early (for example, Cambodia, Myanmar and Thailand), others are only now starting to experience rapidly expanding epidemics and need to mount swift, effective responses. They include Indonesia, Nepal, Viet Nam and several provinces in China. In Myanmar and in parts of India and China, HIV has become well entrenched in some sections of society, despite modest efforts to halt the virus' spread. Other countries are still seeing extremely low levels of HIV prevalence, even among people at high risk of exposure to HIV and have golden opportunities to pre-empt serious outbreaks. These countries include Bangladesh, East Timor, Laos, Pakistan and the Philippines^[2].

China and India, which provide home to some 2.35 billion people, are experiencing several distinct epidemics, some already very serious. Although moving at a varied pace, HIV has spread to all of China's 31 provinces, autonomous regions and municipalities. In some, such as Henan, Anhui and Shandong, HIV was already spreading a decade ago among rural people who sold blood plasma to supplement their incomes. Elsewhere, the virus has established a more recent but firm presence among injecting drug users and, to a lesser extent, sex workers and their clients^[3]. Much of the current spread of HIV in China is also attributable to injecting drug use and paid sex. HIV prevalence among drug injectors was measured at between 18 and 56% in six cities in the

southern provinces of Guangdong and Guangxi in 2002, while in Yunnan province some 21% of injectors tested positive for HIV in 2003^[4].

Sexual transmission of HIV from injecting drug users to their sex partners looks certain to feature more prominently in China's fast-evolving epidemic. Some 47% of surveyed female drug injectors in Sichuan province and 21% in neighboring Yunnan province have been reported selling sex for money or drugs, according to recent studies^[5]. Furthermore, it has been cautioned that once HIV becomes well established in commercial sex circuits, onward spread of the virus could be quite rapid if current behavior trends persist.

India's epidemics are even more diverse than China's. Latest estimates show that about 5.1 million people were living with HIV in India in 2003. Serious epidemics are underway in several states. In Tamil Nadu, HIV prevalence of 50% has been found among sex workers, while in each of Andhra Pradesh, Karnataka, Maharashtra and Nagaland, HIV prevalence has crossed the 1% mark among pregnant women. In Manipur, meanwhile, an epidemic driven by injecting drug use has been in full swing for more than a decade and has acquired a firm presence in the wider population^[6]. HIV prevalence measured at antenatal clinics in the Manipur cities of Imphal and Churachand has risen from below 1% to over 5%, with many of the women testing positive appearing to be the sex partners of male drug injectors. Several factors look set to sustain Manipur's epidemic, including the large proportion (about 20%) of female sex workers who inject drugs and the young ages of many injectors (40% of male injectors surveyed in 2002 were under 25 years of age)^[2].

In seven Indonesian cities, an average 42% of sex workers had either or both gonorrhea or chlamydia in 2003. Condom use ranges from irregular to rare. In 2002, fewer than one in five sex workers operating out of massage parlors and discotheques in Jakarta said they used condoms consistently^[2]. Among sex workers in brothel areas (a group that ought to be easier to reach with interventions), rates of condom use with all clients stood at a meager 4%. The situation is even more troubling in parts of Indonesia's easternmost province of Papua, where HIV prevalence among sex workers in Sorong, for example, had reached 17% by 2003, over five times the national average for sex workers^[2].

In parts of India, Myanmar and China, inadequate prevention efforts have allowed HIV to filter from people with the highest-risk behaviors to their regular sex partners. One in two injecting drug users in Jakarta now test positive for HIV, while in cities such as Pontianak more than 70% of drug injectors are being found to be HIV-positive. There are strong signs that the virus is spreading beyond sex workers and their clients. Household surveys of young men and women in Jayapura and Merauke show that both young men and women in Papua report far less drug use and far more

sexual activity than those in other parts of Indonesia. The data are inconclusive, but they suggest patterns of sexual networking

Prisons are also playing a growing role in Indonesia's emerging epidemic. In Jakarta's jails, HIV prevalence started to rise in 1999, two years after it had taken off among drug injectors, reaching 25% in 2002. Some of the rise reflected the fact that injecting drug users were more likely to have been infected by the time they entered prison. But there is evidence that HIV transmission is occurring inside jails. Surveillance data from a West Java prison has shown HIV prevalence soaring from 1% in 1999 to 21%, either through drug injection with contaminated needles or through unprotected anal sex between prisoners^[7].

Most new HIV infections in Asia occur when men buy sex—and large numbers of men do so. Household-based surveys in a number of Asian countries suggest that between 5% and 10% of men buy sex, which makes commercial sex a large and lucrative industry in Asia^[8,9]. Many sex workers—especially very young women from rural areas—are either coerced into the industry or join it under duress, because they lack other employment opportunities. Estimates reveal that hundreds of thousands of people, including women and children, are trafficked every year. Economic necessity—their own and often that of their families—compels many others to sell or exchange sex temporarily or on an ongoing basis. In some places, still others temporarily opt for selling sex seasonally, when income is low, for example in farming economies^[10]. Studies among sex workers in China, for example, have found that young and ill-educated women from rural areas sell sex because they could not find other work. However, others sometimes opt for the profession instead of arduous, low-paying jobs. In Viet Nam, sex workers have reported earning up to seven times the average income of other workers in the areas where they plied their trade. Their counterparts in Nepal have reported earning around 2200 Rupees or US\$ 30 a week, six times the average wage income^[11].

Who's doing the buying? In southern Viet Nam, sex workers reported that more than one third of their clients were businessmen or white-collar workers. Women selling sex in Indonesia, Laos and Pakistan also said that civil servants and businessmen were among their most frequent clients, while in India, over one-quarter were businessmen or service sector employees^[12,13]. Many of these men are married or in steady relationships. Those who have unprotected sex with sex workers are at risk therefore not just of contracting HIV but also of passing it on to their wives and girlfriends. Indeed, in a study in the southern Chinese city of Guangzhou, some 72% of women with sexually transmitted infections said they had only had sex with their husband or regular partner—a clear sign that they were put at risk by their partners' behavior rather than their own^[14]. Expressed in these ways are

deeper social inequalities, not least the imbalances in men and women's social power and women's stunted earning and career opportunities in most countries of Asia (and, indeed, the world). Prevention efforts that neglect these wider dynamics are likely to achieve just short-lived success, if any.

Data from Japan show that HIV prevalence has risen steadily among male blood donors in that country, while staying relatively stable among women. This suggests that HIV transmission is occurring mainly among men who have sex with men, some of whom might also be transmitting the virus to female sex partners. In 2003, there were some 340 newly-reported HIV cases among Japanese men who had contracted their infection through sex with other men, just over three times the number of reported infections among men who report acquiring the virus heterosexually. Indeed, since 1999 there has been a rapid increase in the annual number of HIV infections attributed to male-to-male sex. A rare survey of men who have sex with men in Beijing, conducted in 2001-2002, found that approximately 3% of the men were HIV-infected^[15].

Because AIDS epidemics criss-cross national boundaries, joint efforts like the border area needle exchange programme run by China and Viet Nam since 2002 make sense. Outreach workers collect used syringes from users for safe disposal and provide vouchers that can be used to acquire new needles from participating pharmacies. The programme grew from the realization that the epidemics among injectors in China's Guangxi province and Viet Nam's Quang Ninh and Langson provinces were closely linked (they share a unique variant of HIV-1 subtype CRF01_AE), due to the fact that the areas straddle a drug trafficking route through the Golden Triangle^[16,17]. The programme is based on a successful trial, which showed a drop in the use of non-sterile injecting equipment from 61 to 30% among all injectors in Guangxi^[5]. Harm-reduction programmes have also helped trigger a dramatic fall in reported non-sterile needle use among injectors in China's Sichuan province. Reported re-use of non-sterile needles at last injection fell from 30 to 17% among male injectors in 2002-2003, while in the same year it fell from 24 to 15% among female injecting drug users^[5].

Forensic considerations of communication in such cases: HIV/AIDS has posed difficult questions for all sectors and spawned a need to debate and forge a holistic framework in which to mount a national response. Some of the more difficult questions have been to do with formulating effective and yet humane and acceptable legal, ethical and policy responses. The quest for such a framework has been precipitated not only by the need to institute and augment a concerted preventive strategy in the absence of a vaccine and therapy. The need to respect, protect, promote and fulfill the rights and freedoms of those affected by

HIV/AIDS that are enshrined in our Constitution has also been a catalyst. Indeed, the protection of human rights constitutes one of the four areas around which the national strategy against HIV/AIDS is structured.

The right to know, not to know and for whom is however not confined to a legal framework but it also interfaces ethical theory. The corollary of this ethico-legal dimension is that the virtues ascribed to legal rights apply *mutatis mutandis* to moral rights. Likewise they are claims imposing correlative duties. The difference between moral and legal rights lies in the mode of enforcement. Legal rights are enforced by the legal system whereas the enforcement of moral rights is left to private individuals and private institutions. This in turn gives rise to three other pertinent questions: (i) Who is entitled to exercise such a right?; (ii) Upon whom does the duty to inform fall; and (iii) What form will the duty to inform take.

The single most factor, however, that has been a barrier against knowing is the fear of stigmatization and discrimination. Acquiring information about one's HIV status ordinarily implies that another person who carried out the diagnostic test and perhaps many more are also privy to the information. Unlike most other epidemics, HIV/AIDS has been the subject of heavy moral censure. The infected and sufferers have been perceived as blameworthy. The affected persons have been made pariahs and subjected to much stigmatization and unfair discrimination in many walks of life including health care, employment, education and social identity. The testimonies of those that are living with HIV/AIDS are replete with anguish and convey a message of intense suffering at the hands of a society that has yet to respond with a sense of equity, empathy, compassion and humanity.

The analogy of an antenatal patient can also be extended to any health carrier-patient relationship. The assumption in the relationship between the carrier and the patient has always been that the latter has, in an ethical and legal sense, a legitimate expectation to be diagnosed of any ailments and that such an expectation imposes upon the health carrier the duty to inform about HIV/AIDS. Such information can only be denied when the patient either expressly or impliedly exercises autonomy to waive the expectation to know or exceptionally when the carrier exercises therapeutic privilege based on reasonable grounds to shield the patient from otherwise harmful information. In both exceptions the rationale for withholding information is to act in the patients best interest by either protecting individual autonomy or desisting from doing harm to the patient.

It is submitted that at the very least, given the sexual dimension to HIV, the spouse or sexual partner of the patient has a right to know and that the person privy to the relevant information has a duty to inform. It is not sufficient merely to confer discretion on the health care worker. For the health care worker may

choose not to disclose for reasons that are not compelling. The law must impose a duty to disclose and place upon the health care worker the onus of justifying non-disclosure. If the matter is left entirely at the level of a professional discretion in what sense then can it be said that the spouse or sexual partner has a right to know when what he or she has is a mere privilege to know?

A discussion on the right to know cannot of course be confined to spouses and third parties. It must also be considered in respect of other third parties, including the state agencies that are responsible for public health, employers, insurers and educational institutions.

The significance of communication can be highlighted in the case of *Tarasoff v. The Regents of the University of California*^[18,19] - An individual, Prosenjit Poddar, became romantically obsessed with the female Tatiana Tarasoff. Poddar related his violent fantasies to his psychotherapist and confided that he might eventually kill her. The psychologist was also aware that Poddar had purchased a gun and, together with a consulting psychiatrist, they recommended that he be hospitalized for further evaluation. The campus police were asked to apprehend Poddar for this involuntary evaluation, but following an interview, the police concluded that he was acting rationally. Rather than apprehend him, they made him promise that he would not harm Tarasoff. Subsequently, he killed Tarasoff and was convicted of second-degree homicide. His criminal conviction was later overturned on other grounds.

A civil suit was brought by Tarasoff's parents against the University of California alleging, among other things, that the defendant failed to notify them or their daughter that she was in danger. The providers involved claimed they could not warn Tatiana Tarasoff, for to do so, would violate patient confidentiality. After several appeals, the California Supreme Court agreed with the Tarasoffs, holding that a doctor can owe a duty to warn a third party when that third party is in danger due to the medical or psychological condition of his patient. According to the court, once a therapist determines, or under professional standards should have determined, "that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger^[2]". The Court did not prescribe a specific means of discharging this duty but observed that several alternate means might be utilized, such as warning the intended victim or others likely to inform the victim, as well as notifying the police.

Since the decision, the identification of the Human Immunodeficiency Virus (HIV) and the increase in numbers of those suffering from the Acquired Immune Deficiency Syndrome (AIDS) have further tested conventional beliefs regarding patient confidentiality and a physician's duty to warn third parties. The two, comparatively recent judgments, deal with the new

question of a physician's duty to warn those who are likely to become infected with HIV. Health care providers should become familiar with these duties imposed by recent court decisions and should examine their own practices for ways to discharge such a duty to warn and thereby limit their liability.

In 1995, *Reisner v. Regents of the University of California*^[20,21], dealt with the issue of whether a physician could be liable for the infection of an unknown third party. In this case, twelve-year-old Jennifer Lawson received HIV infected blood during an April 1985 surgical procedure. Her physician, Dr. Eric Fonklensrud and officials at UCLA Medical Center learned of the blood contamination the day after the procedure. At no time during the next five years of continuing treatment did Dr. Fonklensrud or UCLA inform Jennifer or her parents of the blood contamination. Also, no disclosure was made of the possibility of acquiring AIDS, the dangers of contagion or precautionary measures to prevent the spread of the virus till in 1988, Jennifer met Daniel Reisner and eventually they engaged in sexual relations.

In the words of the court, "Obviously, since Jennifer did not know she had been exposed to AIDS, she could not warn Daniel about the risk he was taking." In March 1990, Jennifer was diagnosed with AIDS as a result of the 1985 transfusion. Jennifer and her parents immediately informed Daniel, who was tested for HIV. A month after informing Daniel of her condition, Jennifer died from AIDS. Shortly thereafter, Daniel was informed he was HIV positive. Daniel then sued UCLA and Dr. Fonklensrud for failing to inform Jennifer or her parents and thereby exposing him to an increased risk of infection.

The primary question before the court was what duty, if any, did UCLA and Dr. Fonklensrud have to Daniel, an unknown third party. The Court of Appeals, relying on the California Supreme Court decision in *Tarasoff v. Regents of the University of California*, found they owed a duty to Daniel, even though they may not have known he existed, to take "whatever ... steps are reasonably necessary under the circumstances." In this instance, the court concluded that the physician's failure to warn and counsel Jennifer and/or her parents prevented Jennifer from warning Daniel. He did not have the option of knowingly assuming the risk, taking precautionary measures, or abstaining from sexual relations with Jennifer. The fact that she was still a minor was of little consequence. The court found that Dr. Fonklensrud should have reasonably known that as she matured, the likelihood would grow that she would engage in sexual activity. While not directly stating it, the court's opinion strongly suggested that had the physician informed Jennifer and her parents regarding her HIV infection along with the risk of infection to third parties, his obligation to any third party would have been fulfilled. (The court left open the possibility that if Daniel had

infected someone else, that person may have also had a legal basis upon which to file suit against Dr. Fonklensrud and UCLA.)

In 1996 the Texas Court of Appeals decision, *Garcia v. Santa Rosa Health Care Corporation*^[22,23]. There, Adalberto Balderas was a hemophiliac who received blood products from Santa Rosa. In the mid-1980s, Santa Rosa Health Care Corporation became aware that some of its blood products had been infected with HIV. Accordingly, it was possible that Mr. Balderas was infected. Mr. Balderas had been scheduled for yearly appointments at Santa Rosa--most of which he failed to keep due to conflicts at work. He claimed that he had not been informed of this possible HIV status until after he became ill and tested positive for AIDS in December 1989. He further claimed that had he known of the possibility, he would have sought testing and earlier treatment.

He met Linda Garcia in 1987 and married her in March 1988. The couple filed suit in 1991 contending that Santa Rosa was negligent in failing to notify them as to his possible HIV exposure. Linda Garcia, fearful of the result, never had follow-up testing to determine whether or not she was infected with HIV. After filing suit, the couple divorced and Mr. Balderas died in 1993. His estate, represented by his mother, voluntarily dismissed the claims made on his behalf, thereby leaving the court to determine what duty, if any, was owed to Garcia as a third party. The trial court granted summary judgment in favor of Santa Rosa. It determined that there was no duty to notify Garcia of her sexual partner's possible HIV status. The trial court further found that the Texas Communicable Disease Prevention and Control Act prohibited the release or disclosure of test results indicating that a person is HIV positive and therefore Santa Rosa could not have informed Garcia without facing criminal and civil penalties.

In reversing and sending the case back for trial, the court of appeals noted that Santa Rosa's initial information, which suggested that Balderas might be infected with HIV, was not a result of testing him. It rather was derived from information regarding the condition of their blood bank, which placed Balderas at "great risk for developing AIDS." The court then went on to hold that the Communicable Disease Act did not prohibit disclosure of non-test related information, which "may be necessary to protect a third party from exposure to AIDS." Noting that Santa Rosa's blood products may have caused the condition, the court, citing Tarasoff, concluded "health care professionals who discover some disease or medical condition which their services or products have likely caused to a particular recipient and endanger a readily identifiable third party, owe a duty to reasonably warn the third party to the extent that such warning may be given without violating any duty of confidentiality to the recipient of services or products." The court further

noted that while Garcia did not, in fact, know she was infected with HIV, she still may have a valid cause of action for the fear and anguish associated with the exposure to HIV sufficient to collect damages.

CONCLUSION

Information about HIV transmission and AIDS treatment and care is essential for any country, community, or person to be able to mount an effective fight against HIV/AIDS. The right to information about HIV/AIDS, though recognized as a core element of the right to the highest attainable standard of health, is far from being fully realized in many developing countries. Survey after survey show that even in countries where there have been HIV/AIDS awareness programs for a fairly long time, large segments of the population appear to be unaware of the basic facts of HIV/AIDS. We dissent from those who suggest that there is no room for compulsory obligations in HIV/AIDS and believe that the current over-reliance on voluntary partner notification is misconceived to the extent that it encourages secrecy. We further believe that a vigorous promotion of a right to know can save lives, however few. The HIV/AIDS epidemiological picture is already worse as it is and we need to rethink our preventive strategy. According to the available figures, women, wives and girl friends have been the major victims of this culture of secrecy in which the health professionals may be aptly termed as conniving parties. It needs to be realized that we cannot combat HIV/AIDS if we succumb to a culture of self-destructing secrecy.

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