HIV/AIDS : MEDICO LEGAL ISSUES

by

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Dedicated to my husband Anup

and our son Zameen

"... the world should make war against AIDS and not against people with AIDS,"

The Secretary-General of the United Nations,
World AIDS Day.

1 December 1988.

ADDENDUM

The phrase "AIDS sufferers" throughout the thesis should be replaced by "people with AIDS". This is in line with the current usage of the term to connote a more positive stand by those living with AIDS.

SINOPSIS

Besar kemungkinan sindrom kurang daya tahan (acquired immuno-deficiency syndrom i.e. AIDS) akan menjadi epidemik yang paling mencabar di abad ini. Para penyeldiik perubatan dan saintis masih belum menemui ubat yang berkesan untuk AIDS apatah lagi ubat untuk mencegah merebaknya virus AIDS. Keadaan ini bertambah buruk dengan ketiadaan undang-undang berkenaan yang dapat meliputi semua isu undang-undang yang mungkin timbul akibat jangkitan virus AIDS dan pelbagai keadaan berkaitan yang mungkin wujud. Tesis ini mengkaji keadaan semasa dan hanya dapat mengemukakan penyelesaian sementara kepada masalah-masalah yang berkaitan.

Bab I memberikan secara ringkas latarbelakang dan sejarah virus AIDS dan AIDS. Data mengenai virus AIDS dan AIDS perlu untuk memberikan suatu gambaran keadaan masakini yang genting. Cara jangkitan virus AIDS dan implikasi jangkitan tersebut dibentangkan di dalam bab ini.

Bab II menghuraikan ujian-ujian yang digunakan untuk mengesan antibodi kepada virus AIDS. Ujian-ujian tersebut adalah "Enzyme-linked Immunosorbant Assay (ELISA)", "particle

agglutination" dan ujian tambahan. Keizinan untuk ujian tersebut dan proses saringan yang dijalankan mengikut 'Plan of Action for the Prevention and Control of AIDS' di bawah Kementerian Kesihatan juga diperbincangkan.

Kesan-kesan sampingan ujian tersebut dikaji dalam Bab III. Fokus kajian ini adalah mengenai akibat dan implikasi ujian tersebut berasaskan undang-undang yang sedia ada di Malaysia. Ini termasuklah kesan terhadap pekerjaan, undang-undang insuran dan perlunya kerahsiaan berkenaan ujian tersebut. Bab IV menyentuh tentang isu-isu spesifik yang berbangkit dari pemberitahuan mengenai keputusan ujian kepada pasangan orang yang telah dijangkiti virus AIDS. Perbincangan di dalam bab ini melibatkan undang-undang kecuaian, undang-undang keluarga dan undang-undang jenayah.

Bab V menghurai dan menganalisa pemakaian undang-undang jenayah ke atas kes-kes jangkitan virus AIDS/AIDS. Isu-isu undang-undang jenayah yang mungkin ditimbulkan adalah 'euthanasia', pembunuhan diri dan pembunuhan. Dalihan-dalihan yang mungkin dikemukakan untuk kesalahan-kesalahan tersebut juga diperbincangkan. Yang lebih utama di dalam bab ini adalah percubaan untuk menilai asas dan tujuan utama undang-undang jenayah dan proses berkenaannya. Kegunaan dan sebab ia digunakan sebagai suatu instrumen untuk hukuman di dalam keadaan-keadaan tertentu ditimbulkan.

Pesakit mempunyai hak untuk menolak rawatan. Namun begitu, bila hak tersebut digunakan oleh pesakit, ada kemungkinan para pengamal perubatan akan menghadapi masalah. Ini adalah kerana sekiranya hak tersebut dihormati, pengamal perubatan berkenaan mungkin telah menyalahi undang-undang jenayah. Penilaian hak ini boleh didapati di dalam Bab VI. Keadaan yang sebaliknya iaitu keengganan untuk merawat juga disentuh di dalam bab ini. Pertimbangan etika, undang-undang jenayah dan sivil serta aturcara disiplin juga dibincangkan.

Bab VII merangkumi kesimpulan serta cadangan-cadangan buat masa ini. Ia terbahagi kepada tiga bahagian iaitu (a) perubahan perundangan; (b) budi-bicara kehakiman dan polisi awam serta, (c) langkah-langkah lain termasuklah pendidikan masyarakat, amalan perubatan yang baik, program perancangan keluarga dan implikasi hak asasi.

Thesis ini tidak merangkumi secara terperinci undang-undang Malaysia dan 'common law' yang terpakai kepada keadaan-keadaan yang berkait dengan virus AIDS/AIDS. Ia hanyalah bertujuan untuk menilai semula secara kasar, keadaan undang-undang semasa yang menyentuh dan meninggalkan kesan kepada pihak-pihak yang terlibat di dalam dilema virus AIDS/AIDS.

SYNOPSIS

"By the year 2000 AIDS could become the largest epidemic of the century, eclipsing the influenza scourge of 1918 ... We are dealing with something that is expanding out of control."[1] Not only have medical and scientific researchers been frustrated by the mounting tragedy of their inability to discover effective treatments (let alone cure) for this "fiendishly fast-moving" disease, there also exists no definitive law(s) to cover all the possible legal issues that will be raised by it. Therefore, in this thesis it is only possible to explore the present situation and (hopefully) present tentative solutions to these problems.

Chapter I gives a brief background and history of the Human Immunodeficiency Virus (HIV) and the Acquired Immunodeficiency Syndrome (AIDS). This discussion is supplemented by data concerning HIV and AIDS to provide an overview of the urgency in respect of the current situation. Modes and implications of HIV transmission have also been included in this chapter.

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1 "Invincible AIDS", Time Magazine, August 3, 1992, No. 31 at pp 17, 20.

Chapter II focuses on the tests utilised by the National AIDS Reference Laboratory for detecting HIV-antibodies. These are the Enzyme-linked Immunosorbent Assay (ELISA), particle agglutination and a supplemental test. Consent for testing and the ongoing screening carried out under the Ministry of Health's Plan of Action for the Prevention and Control of AIDS are also elaborated.

The impact of the medical and scientific tests defined in Chapter II are evaluated in Chapter III. In particular, the various legal consequences and implications of the test for HIV-antibodies based on such applicable laws as exist in Malaysia are highlighted. The major and broader areas touched upon are employment, confidentiality and insurance law. More specific issues such as those arising out of partner notification are dealt with in Chapter IV under negligence law, family law and criminal law.

Chapter V describes and analyses the nature and application of criminal sanctions that may arise with references to HIV/AIDS cases. Euthanasia, suicide, murder and such defences as are available to these offences are particularly highlighted. More importantly, in this chapter, an attempt is made to evaluate the general rationale and

primary purpose of the criminal law and its process. Questions as to its merits and justifications as an instrument of and for punishments in HIV/AIDS situations are raised.

A patient's right to refuse treatment is commonly recognised and acknowledged. However, when he exercises this right the medical practitioner and the health care team are likely to be placed in a difficult position. Chapter VI describes and outlines all the attendant problems that may arise when this happens. Likewise, when the medical practitioner or a health care team refuses to treat a patient, similar difficulties are encountered. Ethical implications, criminal and civil liabilities and medical disciplinary proceedings are explored and presented in Chapter VI.

Various tentative conclusions and proposals are set out in Chapter VII under (a) legislative intervention, (b) judicial discretion and public policy and (c) extra-legal measures which include public education, supportive actions, good medical practice, family planning, programmes on sexually transmitted diseases, pre-marriage test and human rights implications.

This thesis does not attempt to discuss in detail the complexities of Malaysian and common law as applicable to HIV/AIDS situations. It only seeks to broadly appraise the present state of such laws as may likely affect the various parties in a HIV/AIDS dilemma.

ACKNOWLEDGEMENT

In the course of research for this thesis, many challenges have been encountered. Field research have been invaluable in giving an insight to the actual problems facing HIV-infected persons and AIDS patients. My task of writing this thesis have been lightened by the assistance and co-operation rendered to me by a number of people.

I wish to thank both my supervisors, Professor Dr. Molly Cheang and Professor Dr. Dato' Khairuddin Yusof for their invaluable guidance, support and patience. Professor Dr. Molly Cheang's queries and comments have put me back on the right track on numerous occasions and I am grateful to her for her constant supervision. Professor Dr. Dato' Khairuddin's willingness to trudge along with me in exploring the various legal issues is deeply appreciated. Needless to say, their pointers have made this a better thesis than it would otherwise have been.

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Chew Li Hua.

CONTENTS

LIST OF STATUTES

California Natural Death Act 1976.

Civil Law Act 1956 (Act 67).

Contracts Act 1950 (Act 136).

Criminal Procedure Code FMS Cap 6.

Employees Social Security Act 1969 (Act 4).

Employment Act 1955 (Act 165).

Factories and Machinery Act 1967 (Act 139).

Federal Constitution.

Industrial Relations Act 1967.

Insurance Act 1963 (Act 89).

Islamic Family Law (Federal Territory) Act 1984 (Act 303).

Law Reform (Marriage and Divorce) Act 1976 (Act 164).

Limitation Act 1953 (Act 254).

Medical Act 1971 (Act 50).

Penal Code (FMS Cap 45).

Prevention and Control of Infectious Diseases Act 1988 (Act 342).

LIST OF CASES

LIST OF LAW REPORTS

AC	Appeal Cases
AIR	All India Reporter.
ALL ER	All England Law Reports.
Can Bar Rev	The Canadian Bar Review.
CLJ	Criminal Law Journal. Malaysian Current Law Journal
Crim LR	Criminal Law Review
ER	English Reports.
E	Exchequer Cases.
FMSLR	Federated Malay States Law Reports.
ICR	Industrial Court Reports.
IRLR	Industrial Relations Law Reports (Eng).
KB	King's Bench.
Lloyd LR	Lloyd's Law Reports.
LR ... P & D	Probate and Divorce Cases.
LQR	The Law Quarterly Review
MLJ	Malayan Law Journal.
MLR	Modern Law Review
NLJ	New Law Journal
QB	Queen's Bench.
QBD	Queen's Bench Division.
RPC	Reports of Patent Cases.
SASR	South Australian State Reports.
WLR	Weekly Law Reports.

LIST OF ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome.
AIDS related Complex (ARC)	Various symptoms which people infected with the AIDS virus may develop including drenching night sweats, unexpected and considerable weight loss and persistent fever. Part of the clinical expressions now call HIV illness.
Antibody	Protein made by a person's immune defence system in response to an antigenic challenge - usually an infection. If HIV antibodies are present then the body has been infected by the virus.
Antibody tests	The enzyme linked immunosorbent assay (ELISA) is the test commonly used for screening blood. The Western blotting is used for laboratory backup and confirmatory test.
Antigen	Those parts of an organism that cause the body to produce antibodies.
B-lymphocytes	A class of white blood cells that produces antibody (a protein) in response to exposure to a foreign material (antigen).
Candidiasis	A fungal infection of the mucous membranes - commonly known as thrush - and often occuring in the mouth.
CDC	Centres for Disease Control, USA.
DNA	(deoxyribonucleic acid). The carrier of genetic information for all organisms except certain viruses.
"Helper" cells	Are a type of T-lymphocyte which assist the B-lymphoctes in producing antibodies.
HIV	Human immunodeficiency virus; the correct name for the AIDS virus. Earlier names included LAV and HTLV-III.

HIV illness	A spectrum of clinical expressions - including ARC.
Immune deficiency	A situation in which the body's defence system is reduced.
Immune system	The body's defence mechanism which fights off infections and certain diseases.
Incubation period	The time that passes between the agent causing infection entering the body, and the appearance of signs or symptoms of disease.
Index person	HIV infected person.
Intravenous	Into a vein.
Kaposi's sarcoma	A rare type of cancer usually on the skin but also affecting the internal organs which affects about one in four people diagnosed as having AIDS.
Latency	A period when the virus is still in the body, but rests in an inactive state.
Lymph nodes	Lymph nodes are oval structures distributed throughout the body; through which pass the lymphocytes.
Lymphadenopathy	Enlargement of lymph nodes.
Macrophages	Phagocytic cells that ingest micro-organisms or other cells and foreign particles. They interact with B and T cells as part of the immune response.
Opportunistic infections	Infections which occur when the immune system is not working well.
Pneumocystis carinii pneumonia (PCP)	A rare form of pneumonia. It usually does not cause a recognised infection in a person with an intact immune system. This is the most common form of presentation of people with AIDS. Is associated with a high death rate.

RNA	Ribonucleic acid.
Seropositive	Blood which contains a particular antibody. Someone who is seropositive for HIV has antibodies to the AIDS virus in his or her blood.
STD	Sexually transmitted disease. Diseases such as gonorrhoea, syphilis, chlamydia and HIV infection which can be passed on during sexual activity.
Syndrome	A set of symptoms and signs indicating the presence of a particular disease.
T-lymphocytes	Cells derived from white blood cells which have matured in the thymus gland in the neck. There are two kind of T-lymphocytes (T cells): helpers and suppressors. In AIDS the normal ratio of helper to suppressor is often reversed.
Virus	A tiny agent or particle which can only reproduce inside a living cell. Many human disease, such as measles, colds, and chickenpox are caused by different kinds of viruses.

CHAPTER I

INTRODUCTION

A. Background and history

Medico-legal issues confronting doctors, other health-care providers and their patients have grown and will continue to grow with the development and advancement in the medical science. The increase in specialisation also contributes to growing legal issues in the medical field. Recent years have seen, at its best, haphazard development in the tackling of medico-legal issues due to the fact that it has mainly been dealt with on an ad-hoc basis.

This thesis will focus on the legal issues surrounding the transmission of the human immunodeficiency virus (HIV), the tests to detect antibodies to the virus, confidentiality of the tests and their results, effects and efficacy thereof and efforts to control, prevent the epidemic and the management of HIV infected persons and patients with the acquired immunodeficiency syndrome (AIDS).

AIDS raises a spectrum of legal issues affecting the individual, his/her spouse, family members, colleagues at work and last but not least, the general public. Some of the

questions which need to be addressed are: Should spouses, family members and others be informed of the status of the patient? Would it amount to a breach of confidentiality and affect the doctor- patient relationship? Can a person be dismissed from his job for testing seropositive? Should there be a special hospital dealing with HIV positive patients and AIDS sufferers? What about the patient himself? Can the patient refuse treatment? These are only some of the questions often asked and in this thesis an attempt will be made to examine these and such other related issues within the realms of possibility in a given situation with respect to HIV and AIDS.

The virus causing acquired immunodeficiency was first recognised in the summer of 1981 and was discovered only in 1983.[1] The human immunodeficiency virus (HIV) (previously known as LAV/HTLV-III)[2] attacks the T4 helper cells which are responsible for the body's defence mechanism against diseases. Destruction of the cells would allow opportunistic infections to set in. The HIV is a retrovirus, i.e. it is slow-acting and not highly infectious.[3]

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1 'Controlling AIDS : Some Legal Issues' New Law Journal, April 15, 1988 at p. 254.

2 Lymphadenopathy Associated Virus/Human T-Cell Lymphotropic Virus Type III.

3 AIDS : A Guide To The Law, Routledge, London and New York, 1990.

Not every person who had been infected by the HIV however would develop Acquired Immunodeficiency Syndrome (AIDS). Most people with HIV remain healthy for several years after the infection. The incubation period between infection and the development of AIDS is long (an average of eight years)[4]. Statistics from various authorities vary in their predictions as to the chances of a person infected with HIV developing AIDS. It still remains unclear as to whether everyone with HIV infection will develop AIDS or even become ill. However, because HIV infection is presumably lifelong, the risk of illness may continue throughout the infected person's life.

To date, it is undisputed that HIV infection is more common than AIDS. At the beginning of 1989 in the United Kingdom, there was an estimated of 60,000 to 100,000 persons infected with HIV compared with less than 2,000 diagnosed with AIDS.[5] It is however undeniable that the number of people with AIDS is rising sharply. The global incidence of AIDS as at 1st January 1992 shows a cumulative total of 446,681 cases compared to 298,914 cases on 1st November 1990.[6] The data were compiled by the World Health Organisation (WHO) from 163 countries.

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4 Report of an International Consultation on AIDS and Human Rights, UN, New York, 1991 at p 30.

5 AIDS : A Guide to the Law, Routledge, London & New York, 1990.

6 Update : AIDS Cases Reported To Surveillance, Forecasting and Impact Assessment Unit, Office of Research, Global Programme on AIDS, 1 Jan 1992, WHO, Geneva.

WHO has projected that by the year 2000, there would be a cumulative total of five to six million AIDS cases in adults and between fifteen to twenty million adults cumulatively HIV-infected. Infants born HIV- infected since the start of the pandemic may reach ten million by the end of the century.[7]

The current position is represented by an increasing trend in terms of quantity, region and prevalance as can be seen in Figures 1 and 2. There is no longer any truth in saying that HIV and AIDS are confined to specific groups only. The initial detection in 1981 in the United States was among the homosexuals but the grip of the infection and AIDS have grown beyond that limited group into the unsuspecting general public.

In Malaysia, the government agency responsible for monitoring the statistics of HIV and AIDS is the Ministry of Health. The data as in Figure 3 refers to the reported number of HIV infected persons in Malaysia for the period 1985 - 30.4.92. The classification of HIV infected persons in Malaysia for the same period in Figure 4 is based on the number of reported cases.

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7 Report of an International Consultation on AIDS and Human Rights, Centre for Human Rights, UN, New York, 1991.

FIGURE 1

AIDS Cases Reported to WHO by Year as of : 01.01.1992

Continent	1982*	1983	1984	1985	1986	1987	1988	1989	1990	1991	Total
Africa	3	17	187	579	3,569	13,945	24,009	35,752	39,277	11,728	129,066
Americas	1,713	3,384	6,707	21,805	21,317	33,454	42,387	48,030	49,029	34,151	252,977
Asia	3	8	7	31	83	121	150	261	414	176	1,254
Europe	127	277	650	1,761	3,579	6,791	10,156	13,122	14,134	9,598	60,195
Oceania	1	10	52	135	249	412	588	656	681	405	3,189
Total	**1,847**	**3,696**	**7,603**	**15,311**	**28,797**	**54,723**	**77,290**	**97,821**	**103,535**	**56,068**	**446,681**

* includes cases reported prior to 1982

Source: Update: AIDS Cases reported To Surveillance, Forecasting and Impact Assessment Unit, Office of Research Global Programme on AIDS,, WHO, Geneva,1 Jan 1992

FIGURE 2

Cumulative AIDS Cases Reported to WHO by Year as of : 01.01.1992

Continent	1982*	1983	1984	1985	1986	1987	1988	1989	1990	1991	Total
Africa	3	20	207	786	4,355	18,300	42,309	78,061	117,338	129,066	129,077
Americas	1,713	5,097	11,804	24,609	45,926	79,380	121,767	169,797	218,826	252,977	252,977
Asia	3	11	18	49	132	253	403	664	1,078	1,254	1,254
Europe	127	404	1,054	2,815	6,394	13,185	23,341	36,463	50,597	60,195	60,195
Oceania	1	11	63	198	447	859	1,447	2,103	2,784	3,189	3,189
Total	**1,847**	**5,534**	**13,146**	**28,457**	**57,254**	**111,977**	**189,267**	**287,088**	**390,623**	**446,681**	**446,681**

* includes cases reported prior to 1982

Source: Update: AIDS Cases reported To Surveillance, Forecasting and Impact Assessment Unit, Office of Research Global Programme on AIDS,, WHO, Geneva,1 Jan 1992.

FIGURE 3

NUMBER OF HIV INFECTED PERSONS
DETECTED IN MALAYSIA BY YEAR
1985 - 30.4.1992

Year	Cases	Carriers
1985	0	0
1986	1	3
1987	1 (2)*	4
1988	4 (3)	19
1989	6 (3)	177
1990	12 (8)*	650
1991	14 (14)	1672
1992 (30.4.92)	9 (4)	702
TOTAL	47 (34)	3227

() - Indicates Death

* - Deaths include cases detected in previous year(s)

Source: Ministry of Health.

FIGURE 4

CLASSIFICATION OF HIV INFECTED PERSONS
IN MALAYSIA SINCE 1985 TO 30.4.1992

A. By Age Groups

Age Groups	Cases	Carriers
0 - 5 yrs	1 (1)	6
6 - 10 yrs	1 (1)	2
11 - 15 yrs	0	8
16 - 20 yrs	0	178
21 - 25 yrs	5 (2)	679
26 - 30 yrs	17 (11)	1076
31 - 35 yrs	11 (7)	753
36 - 40 yrs	6 (6)	359
41 - 45 yrs	3 (3)	109
46 - 50 yrs	2 (2)	35
> - 50 yrs	1 (1)	22
Total	47 (34)	3227
Percentage (%)	1.4	98.6

() Indicates those who have died.

Source: Ministry of Health.

FIGURE 4 (Cont)

B. By Sex	Cases	Carriers
Male	41 (29)	3116
Female	6 (5)	111
Total	47 (34)	3227

C. By Risk Factors	Cases	Carriers
1. Homosexual	6 (6)	23
2. Heterosexual	5 (2)	58
3. Bisexual	12 (10)	9
4. Prostitute	2 (2)	58
5. IVDU*	14 (8)	2616
6. Blood Products/ Transfusion Recipients	5 (4)	10
7. Organ/Tissue Transplant Recipients	1	3
8. Born infected (Paediatric AIDS)	1 (1)	5 **
9. Others/Under Investigation/ Unknown	1 (1)	445
Total	47 (34)	3227

* Includes Drug Suspects/Addicts and prisoners.

() Indicates those who have died.

** Temporarily classified pending maternal antibody interference being ruled out.

Source: Ministry of Health.

One has to look at the modes of transmission to see the rapid change of scene in the HIV/AIDS pandemic. So far, HIV has been isolated from blood, semen, vaginal secretions, saliva, tears, breast milk and urine and is likely to be present in other body fluids, secretions and excretions. Extensive laboratory and epidemiological studies indicate that only blood, semen and vaginal/cervical secretions are presently recognised as important in the transmission of HIV.

B. Modes of Transmission and Implications

Studies have repeatedly documented only three routes of HIV transmission:

(i) sexual contact by heterosexual or homosexual intercourse;

(ii) parenteral route by blood or blood products (including transfusion of unscreened blood and the use of inadequately sterilised syringes and needles); and

(iii) pregnancy and perinatal, from an infected mother to her foetus or infant.[8]

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8 Report of an International Consultation on AIDS and Human Rights, UN, New York, 1991 at p 30.

There is no conclusive evidence to date to suggest that HIV can be transmitted by other routes or by casual person-to-person contact in any setting be it household, social, work, school or prison environments. There is also no conclusive evidence that HIV can be transmitted via insects, food, water, toilets-sharing-usage, swimming pools, sweat, tears, shared eating and drinking utensils, clothing or telephones.

The fears that one may be infected by talking, shaking hands or using utensils touched by HIV-infected persons are unfounded. In such situations, infection can only occur if there is direct contact with the infected blood. For example, even if the toilet seat is smeared with infected blood, there is no possibility of infection if there is no direct contact with an open wound or sores on the subsequent users. In addition, being a retrovirus, the HIV cannot survive for very long outside the body. Hugging and casual kissing on the cheeks and lips of HIV infected persons would not result in being infected unless there is a direct contact of blood via an open wound or sore. Despite the fact that HIV has been isolated from saliva, tears, breast milk and urine, there have been no cases reported so far of persons being infected in this manner. Perhaps the concentration of HIV in them are not sufficient to cause an infection. Nevertheless, the universal

precaution recommended by WHO in dealing with the blood and other bodily fluids of an HIV infected person ought to be practised.[9]

Transmission of HIV can and does occur in health- care settings. Transmission from an infected patient to a health-care worker has been documented after a mucous- membrane exposure to blood. This risk however is less than one percent and is limited to exposure to blood. The risk is further minimized through strict adherence to routine infection-control measures.[10]

HIV causes a range of illnesses of which AIDS is one. Others include various infections such as a relatively non-serious inflammation of the glands called Persistent Generalized Lymphadenopathy (PGL), and AIDS-related Complex (ARC) which causes some debilitating conditions like fevers, oral thrush, night sweats and loss of weight. HIV may also cause dementia in people with AIDS and ARC.[11]

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9 The universal precautions recommended include the using of gloves when dealing with the bodily fluids of an HIV infected person and using bleach to clean utensils or surfaces where such bodily fluids have contaminated.

10 'Transmission of human immunodeficiency virus (HIV) in health-care settings worldwide', Bulletin of the World Health Organization, 67(5): 577-582 (1989). WHO.

11 See Appendix 1 for the definition of AIDS for AIDS surveillance purposes in the Malaysian reporting scheme of which the CDC/WHO case definition had been adopted.

As part of the effort to control and prevent the spread of HIV infection and AIDS, it is essential that correct information regarding AIDS and the various modes of HIV transmission be disseminated to the public. Many of the issues, legal or otherwise, stem from myths and misconceptions of the modes of HIV transmission. Out of fear, ignorance and prejudice, various issues are made complicated. The calls made by the general public and sometimes the authorities themselves, to isolate HIV-infected persons in various settings such as the prison, corrective and rehabilitative centres, workplace and schools stems from such fear, ignorance and prejudice. The desperate attempt to curb the spread of the HIV infection and AIDS often lead to hysterical measures like isolation.

The Ministry of Health had in fact entertained the idea of setting up a special hospital to treat AIDS patients with the aim of not only giving the necessary treatment but also separate them from other patients.'[12] The idea was however, subsequently dropped.

Recognising the urgent need to eradicate ignorance, fear and prejudice, the World Health Organisation took the initiative with its Global Programme on AIDS. Similar efforts are being carried out locally by the Ministry of Health

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12 The STAR, 25.1.1992 and 13.2.1992.

together with various organisations and related Ministries. These comprise mainly of health education and information dissemination to the general population and specific target groups.[13] At the same time, preventive measures such as screening of all donated blood in 54 screening centres in the country,[14] the judicious use of blood and centrally purchased imported blood products with the requirement of an HIV free certificate from the suppliers have been implemented.

Surveillance of HIV infections among people with high risk behaviour are also carried out. Training for health care workers are being conducted to enable them to handle and treat patients with HIV infection and/or AIDS with the necessary universal precautions and without fear or prejudice.

Questions, issues and problems highlighted in the foregoing paragraphs represent some of the identifiable areas that need to be explored, analysed and reviewed. In the following chapters, it will therefore be the intent of this thesis to address them.

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13 Source: Interview with Dr Jit Singh of the Ministry of Health dated 9th July 1992.

14 See Appendix 2.

CHAPTER II

TEST FOR HIV-ANTIBODIES

The World Health Organisation (WHO) has adopted an anti-discrimination resolution on AIDS, recognising that it is vital to the success of the efforts at national and international levels to curb and control the spread of HIV infection and AIDS.[1] It is acknowledged that measures based on the explicit, free and informed consent of the persons concerned seemed to comply with international human rights standard.[2] These include the voluntary testing of individuals for HIV infection, anonymously or otherwise, with stringent safeguards for confidentiality, pre and post-test counselling, voluntary treatment to mitigate the effects of HIV infection and voluntary modifications of the behaviour of HIV-infected individuals to prevent the transmission of the virus.

Emphasis has been laid on voluntary measures as they not only comply with international human rights standard as found in the various relevant international declarations[3] but more

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1 At the 41st World Health Assembly held in Geneva, May 2-13, 1988.

2 Report of an International Consultation on AIDS and Human Rights, United Nations, New York, 1991.

3 Universal Declaration of Human Rights.

importantly, the fact that they are more effective in achieving better results in national and international efforts of controlling and preventing the spread of HIV infection and AIDS. Voluntary participation is essential especially for modifications of the behaviour of HIV-infected persons as the method of forced change of behaviour can only work to a certain extent, entailing with it more costs such as the recruiting and training of more enforcement officers, the accommodation of and meals for the affected individuals and constant surveillance to ensure modified behaviour. The last would prove extremely difficult as it would involve close surveillance since the behaviour pattern concerned is that of a private and personal nature such as sexual practices.

It would be impractical especially in terms of finance to adopt a method of forced change of behaviour when it can be easily achieved by the voluntary participation of the individuals concerned. The latter need only the proper counselling of such individuals to ensure understanding of the crucial importance of their role in the prevention of the spread of HIV infection and AIDS. Furthermore, most of the infected individuals being in the economically productive group, i.e. between twenty to forty five years old, it would be a great loss to society if they are to be placed in such a situation that would not enable them to work whilst they still can such as confining them in an institution.

The consequences and implications of the test for HIV-antibodies via a blood test are varied and numerous. These however are not entirely of legal significance as they encompass the social and economic aspects as well. Nevertheless, these consequences and implications need to be considered in the effort to promote the prevention and control of the spread of HIV infection and AIDS.

A. Tests Available in Malaysia

It is acknowledged by the Ministry of Health that because of the seriousness and implication of HIV infection and AIDS, its diagnosis must be done with great care. The diagnosis is based on clinical and laboratory evidence. In Malaysia, three types of tests are currently available and adopted to assist in the final diagnosis. These are the:

(i) Enzyme-linked Immunosorbent Assay (ELISA)
(ii) Particle agglutination and a
(iii) Supplemental test.[4]

The common test used in the initial stage at various sources e.g. private clinics, district hospitals and blood bank is the ELISA. The ELISA test was licensed by the Food and Drug

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4 The Western blot Assays was used until replaced recently in September 1992 by a modified immunoblot assay called Lia Tek HIV 1 + 2.

Authority of the United States of America in 1985 to detect antibodies to the HIV in samples of blood. Not then or since then has it been approved as a screening test. The ELISA test has an approximately 10 percent incidence of false results due to its sensitivity[5]. This lack of accuracy is the result of a constraint of technology. However, in spite of the constraint it has been widely used as a screening test.[6] It therefore borders on the infringement of human rights in several instances. In Malaysia when the test is positive initially and the relevant authorities are informed, a sample of the blood will be sent to the National AIDS Reference Laboratory (NARL)[7] for confirmation of the seropositivity.

At the NARL, two tests are conducted at the screening stage. These are the ELISA and the particle agglutination tests. If only one of the tests returns a positive result whereas the other is a negative, another sample of the blood would be requested for another test, usually in three to six months' time. Such a result is termed 'equivocal'. If the second sample yield a similar result i.e. one positive and

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5 Infra, footnote 7. Confirmed by Dr. Vijayamalar of National AIDS Reference Laboratory, IMR during interviews in November-December 1992.

6 HIV testing : principles and policy, David Buchanan, National AIDS Bulletin, Australian Federation of AIDS Organisation Inc), Vol 4, No 6, July 1990.

7 Division of Virus Research, Institute for Medical Research, Jalan Pahang, 50588 Kuala Lumpur.

the other negative (usually the ELISA would render the positive result due to its sensitivity[8]), then the result is a 'false positive' or non-reactive. Background information of the subject is referred to to assist in the classification of the status.

Where both the ELISA and particle agglutination tests are positive, a supplementary test is carried out. A supplemental test is one that is recognised for its specificity.[9] Prior to September 1992, the Western blot Assays was used at the NARL. A modified immunoblot assay known as Lia Tek HIV 1 + 2 has been adopted in its place. This test can detect not only HIV-1 but HIV-2 as well. So far, no HIV-2 has been detected as yet in Malaysia.[10]

If the result is indeterminate, a repeat will be carried out in three to six months' time. Again, background information form a crucial factor in determining the status of the subject. A positive result at the confirmatory stage would confirm the earlier results of the ELISA and the particle

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8 Sensitivity - the probability that an individual who has antibody to HIV will be positive in the test. A test with high sensitivity will give few false negative results. This is therefore important when screening donated blood for antibody to HIV.

9 Specificity - the probability that an individual who has no antibody will be negative in the test. A test with high specificity will give few false positive results.

10 As of 1st November 1992.

agglutination test. The Ministry of Health has set up 54 screening centres for HIV infections throughout Malaysia.[11]

Another test available at the IMR[12] is the test for T - lymphocyte enumeration of HIV antibody positive cases. The T - cell enumeration test as it is known is by prior appointment and is utilised to monitor the progress of the HIV antibody positive cases. This is particularly useful in the monitoring and the treatment of the opportunistic infections attacking the patient. The test is not used for screening purposes.

B. Test Procedure

In carrying out the various tests, certain procedures are followed to ensure safety and reliable results. The proper collection and labelling of the blood sample at the initial stage are to ensure that there will be no mix up of the samples, thus minimising the chances of 'mistaken identity'.

(1) ELISA

The Enzyme-linked Immunosorbent Assay is a test used for the detection of antibody to the HIV-1 and HIV-2 in human serum or plasma. The test previously used at the NARL was a competitive

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11 The designated screening centres are listed in Appendix 2.

12 Division of Immunology, Institute for Medical Research.

enzyme immunoassay which can only detect HIV-1 and will be elaborated later. In an ELISA, an enzyme-substrate system is used to visualise specific binding of anti-HIV with HIV antigen. Most ELISA systems can be summarised as follows:

(i) HIV antigen is fixed on the surface of a test well of a microtitration plate by the manufacturer.

(ii) Patients' serum or control serum is added by the laboratory and these are incubated at 37°C. HIV antibody, if present in the patient's serum will attach to the HIV antigen in the well, forming an antigen-antibody complex.

(iii) After washing, an enzyme 'conjugate reagent' is added and the test reincubated.[13] The enzyme-conjugated anti-human IgG attaches to the HIV antigen-antibody complex.

(iv) After washing a substrate-chromogen reagent is added. This is acted on by the enzyme and a colour is produced.

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13 The reagent usually consists of an anti-human IgG (immunoglobin) to which an enzyme such as peroxidase has been conjugated (joined).

(v) A 'stop' reagent solution is then added to stop the reaction.

(vi) The colour produced in the patient's and control wells is then measured.

(vii) The HIV antibody level in the patient's serum is calculated.

In a competitive ELISA, as in the one previously used at the NARL, the patient's serum or control serum is incubated with enzyme conjugate in the HIV antigen-coated well and competes for antigen binding-sites. The HIV antibody, if present in the patient's serum will bind to the HIV antigen, preventing the enzyme conjugate from binding to it. After washing the substrate-chromogen is added. A colour will only be produced if there is any bound enzyme. Thus, the more HIV antibody is present the less enzyme will have been bound resulting in a weaker colour. The colour in the wells is therefore inversely related to the concentration of HIV antibody in the patient's and control sera.

Competitive ELISA systems can help reduce non-specific reactions and reduce the testing time, there being one less incubation stage. However, it can only be used when testing for either HIV-1 or HIV-2. It cannot be used for combined HIV assays.

At present the NARL uses a combined enzyme immunoassay for the simultaneous detection of antibodies to HIV-1 and/or HIV-2 in human serum or plasma. In this test, human serum or plasma is diluted in a specimen diluent and incubated with a polystyrene bead coated with RECOMBINANT HIV-1 Env and Gag and HIV-2 Env proteins. If anti-HIV-antibodies are present in the sample, these antibodies will react with the antigens on the coated bead. After aspiration of the unbound materials and washing of the bead, specific human immunoglobulins remaining bound to the solid phase are detected by incubating the bead-antigen-antibody complex with a solution containing HIV-1 Gag and Env together with HIV-2 Env RECOMBINANT proteins labelled with horseradish peroxidese.

Unbound enzyme conjugate is then aspirated and the beads are washed. Next, O-Phenylenediamine solution containing hydrogen peroxide is added to the bead and, after incubation, a yellow-orange colour develops in proportion to the amount of anti HIV-1 and/or anti-HIV-2 which is bound to the bead. Specimens which produce absorbance values less than the cutoff value are considered negative for antibody. A specimen found initially reactive by this test should be retested in duplicate using the original sample source. Reactivity in either or both of these duplicate tests i.e. repeatedly reactive, is highly predictive of the preserve of HIV-1 and/or HIV-2 antibodies.

(2) Particle agglutination test to detect antibody to HIV

The test used at the NARL is the Serodia-HIV test.[14] The test is simple (using a microtiter technique) and is particularly suitable for mass-screening of specimens. It is time-saving and the results are readable by the naked eye after about two hours. In this test gelatin particles are sensitized with HIV-1 antigen and incubated with the diluted test serum in the well of a microtitration plate. After mixing and two hours of incubation at room temperature, each well is examined for its agglutination pattern. A control is set up for each test using non-sensitized particles. The test is based on the principle that the sensitized particles are agglutinated by the presence of antibodies to HIV in serum or plasma specimens.

Where HIV antibody has joined with the antigen there is a fine covering of agglutinated particles in the bottom of the well. A negative reaction is shown by a compact button of non-agglutinated particles in the bottom of the well. The agglutination patterns must be read in good light. Adequate training in the performance, reading and interpretation of results is essential. At the NARL, both the ELISA and Serodia-HIV are run concurrently.

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[14] Manufactured by Fujirebio Inc.

(3) Western blot Assays

The test is also known as immunoblotting. Western Blot (WB) detects antibodies against the complex mixture of antigens found in HIV infection. This is a highly specific technique. The NARL previously used the HIV-1 Western Blot test as its confirmatory test.

(i) In this assay, inactivated and disrupted proteins of HIV-1 are separated by electrophoresis according to molecular weight using a poly-acrylamide gel in the presence of sodium dodecyl sulfate. The lower molecular weight proteins (p 17, p 24) migrate further in the gel and the higher molecular weight proteins (gy 160/120) remain nearer the origin.

(ii) The resolved protein bands are then transferred (blotted) to nitrocellulose paper electrophoretically and the paper is then dried and cut into strips.

(iii) The strips are then incubated with a dilution of the test serum, washed and incubated with a conjugate labelled with an enzyme. If virus-specific antibody is present, binding

occurs in bands corresponding to those produced by viral antigens. A coloured band is produced when the enzyme acts upon the substrate.

(iv) Positive and negative controls are run with each assay.

The WB is more sensitive for the detection of anti-p24 than anti-gp41 because glycoproteins do not transfer as well to the nitrocellulose paper. Interpretation of WB can be difficult and subjective where bands are faint. WB is also expensive and time-consuming. The test used was also limited to HIV-1 only. Thus, the NARL has adopted another supplemental test i.e. a modified immunoblot or line immunoassay known as Lia-Tek HIV 1+2.

(4) Line immunoassay

This test[15] was recently adopted by the NARL to replace the WB as a confirmatory test. It is a line immunoassay for the differential detection of antibodies to HIV-1 and HIV-2 in human serum or plasma. It is based on a 'sandwich' principle.

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15 Lia-Tek^{R} HIV 1+2.

Anti-human IgG (goat) coupled to alkaline phosphatase serves as the conjugate with bromochloro- indolylphosphate (BCIP) as the substrate. Upon completion of the test colour development suggests the presence of specific HIV-1 and/or HIV-2 antibodies. A control line is also coated on the strip in addition to human IgG control, cut off lines and anti-human IgG sample addition control line. There are various steps of incubation in the test. If the sample is free of specific HIV-1 and HIV-2 antibodies, no colour develops. The test procedure is as stated below:

1. Fit the tray with the required number of troughs with assigned strips. Include two troughs for the controls.

2. Pipet 1 ml sample diluent into each test trough. (Do not pipet sample diluent into control troughs.)

3. Add 1 ml test sample to each test trough.

4. Pipet 1 ml of each control into the control troughs.

5. Incubate and shake for 60 minutes at 20-25°C, or cover the troughs with place sealer and incubate and shake for 14-18 hours at 20-25°C.

6. Wash each strip three times with diluted wash buffer.

7. Pipet 1 ml diluted conjugate into each trough.

8. Incubate and shake for 30 minutes at 20-25°C.

9. Wash each strip three times with diluted wash buffer.

10. Pipet 1 ml diluted substrate into each trough.

11. Incubate and shake for 30 minutes at 20-25°C.

12. Aspirate the liquid. Pipet 1 ml sulfuric acid into each trough.

13. Incubate and shake for 10-30 minutes at 20-25°C.

14. Place the strips with the **coated membrane side up** on absorbent tissue and **dry completely**, e.g., with a hot air fan for 5 minutes or in the dark at 20-25°C for 30 minutes.

(5) T-cell enumeration test

The test involves the immunophenotyping of lymphocyte populations. It utilises the reaction between the marker antigens and their corresponding specific monoclonal antibodies to enumerate the CD4 and CD8 T-lymphocytes and their ratios using computerised flowcytometer. The CD4 cell is the T-helper lymphocyte in the human body. It is this cell that the HIV would attach itself to, invade and finally undergo the replication process in. Once activated the DNA[16] produces copies of viral RNA[17] and viral proteins instead of that of the cell's. The mature HIV leave the host cell by a process called budding. The active process of buddings causes the rupture and death of CD4 lymphocytes. When this happens, the CD4 population would be reduced compared to that of the CD8. The reduction in the number of CD4 T-lymphocyte is an extremely useful indicator of the state of the disease in a patient infected with HIV. In fact, the Center for Communicable Disease Control in the United States of America has recently added a critereon where an HIV positive patient is diagnosed as a case of AIDS if the CD4 T-lymphocyte count is below 200 cells per cubic millimeter.

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16 Deoxyribonucleic acid.

17 Ribonucleic acid.

The immunophenotyping of lymphocyte population carried out at the IMR[18] uses the flowcytometry method. The steps to be followed in the laboratory to carry out the test are as stated below:

(i) 2-3 mls of blood is collected in anticoagulant to prevent it from clotting. It is to be processed preferably within six hours of collection.

(ii) The blood is analysed for the breakdown of its cells.

(iii) 0.02 ml of monoclonal antibody conjugate is placed at the bottom of the six Falcon tubes.

(iv) 0.1 ml of blood is mixed carefully with the monoclonal antibodies ensuring that the sides of the test tube is not smeared with blood.

(v) The tubes are then placed at the vortex individually to ensure that the mixture is properly combined.

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18 Institute for Medical Research.

(vi) The test tubes are then incubated for 15 minutes in the dark at 4 degrees Celcius.

(vii) After incubation, 2 mls of lysing solution is added to each tube to break down the red blood cells. The tubes are again individually placed at the Vortex to combine the solution with the mixture via the vibrations. The tubes are then incubated for between 5-8 minutes at room temparature in the dark. They are then centrifuged for 5 minutes at 300 g.

(viii) After centrifugation the supernatant is discarded into a disinfecting solution e.g. a hypochloride solution.

(ix) The remaining white blood cells are washed by resuspending in 2 mls of cold filter sterilised Phosphate Buffered Saline (PBS) (pH 7.2). The tubes are again placed at the Vortex and subsequently centrifuged for 5 minutes at 300 g.

(x) Step (viii) is repeated.

(xi) The cells are then resuspended in 0.4 mls of cold filter sterilised PBS (pH 7.2) with 1% formaldehyde.

(xii) The tubes are stored in the dark at 4 degrees Celcius until analysed.

(xiii) The analysis of the white cells is computer-assisted with the machine FASCSAN. The process of analysis involves the enumeration of the various components in the white cells by the computer. It takes approximately an hour for a blood sample to be analysed.

(xiv) The test result is then printed by the computer giving a complete reading of the enumeration of the T and B lymphocytes.

The test above is carried out with a control to ensure accuracy and to enable detection of errors.

Besides the tests above, the various diseases or conditions suggestive of AIDS are acceptable methods that can be utilised to assist in diagnosing AIDS patients. These are as listed in the Guidelines for Laboratory Diagnosis of HIV Infection - Other Specimens, Appendix 4 of the Ministry of Health's Plan of Action For The Prevention and Control of AIDS.[19]

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[19] Appendix 3.

C. Consent for testing

The concept of consent is based on the premise of the ethical principle of respect for an individual's autonomy. In the case of HIV testing, the issue of consent has been the subject of heated debates and has been controversial.[20] It is undeniable that testing for HIV antibodies requires the consent of the patient. Consent is necessary as the testing involves the 'invasion' to a person's body. Any physical contact with the body of a person without his/her consent would amount to a form of trespass to person, i.e. battery. Battery has been defined as the intentional and direct application of force to another person.[21] The term 'force' has been given a wide definition by the courts. The drawing of blood for HIV antibodies testing therefore requires consent. Although no physical hurt results, all forms of trespass are actionable per se. It is thus crucial for the doctor or the health care worker concerned to obtain the consent of the patient.

The question that has arisen is whether the said consent should be of a specific nature or would an implied consent suffice?

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20 KM Boyd, 'HIV Infection: The Ethics of Anonymised Testing and of Testing Pregnant Women' (1990) 16 J Med Ethic 173.

21 Winfield & Jolowitz on TORT, 13th ed, London, Sweet & Maxwell, 1989 at p 54.

The standard practice today is to obtain the written consent of the patient.[22] Thus, it can also be referred to as an expressed consent. This however, assumes that the patient understands and knows what the procedure is all about. The essential element of such an assumption would be the knowledge and understanding of the patient. If the procedure and its consequences has been explained to the patient, and the patient thereafter consents, it is an informed consent.

Due to the nature and consequences of a positive serological test, it is submitted that prior to consent being given, relevant information relating to the matter be given to the patient so as to enable him to give a meaningful consent.

The fact that the consent form covers this aspect confirms the importance of the matter.[23] The doctor treating has to explain the manner, aim and implications of the blood test for HIV antibodies. Further information that can be obtained via a pre-test counselling has also been included in the consent form.

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22 See Appendix 4.1, 4.2 and 4.3.

23 See Appendix 4.1.

It can therefore be concluded that insofar as the procedures practiced in government hospitals in Malaysia are concerned, information relating to the manner, aim and implications of the test and pre-test counselling are prerequisites to the consent.

The practice in government hospitals in Malaysia follow a set procedure in the testing for HIV antibodies. Any patient who wants to undergo the test for HIV antibodies are referred to a counsellor, usually from the Social Work Unit, who would proceed with a pre-test counselling. If, after the pre-test counselling the patient is still willing to go through the test, he is then referred back to the doctor who would then proceed with the test.

The patient would be given an appointment for the test result. Post-test counselling is rendered regardless of the status. A positive result would entail counselling aimed at assisting the patient to learn to live with the condition. A thorough explanation or answering and clearing of doubts and fears would ensue. A negative result, on the other hand, requires the counsellor to advise the patient that it is not a life-long protection from HIV transmission and that a change in high risk behaviour is necessary to minimise the risk of HIV transmission in the future. The other aspect that would be pointed out is the possibility of the test being carried out

during the 'window period' whereby the antibodies have either not developed or have been destroyed by the virus. This would result in a false negative test result.

It can thus be safely concluded that where the procedure outlined above is strictly adhered to, the consent given by the patient is an informed one. This practice is however, confined to those who voluntarily approach government hospitals for the said test. Although there is a legal requirement for mandatory notification of infectious diseases of which Human Immodificiency Virus Infection (all forms) is included,[24] there is as it stands, no requirement at all for the consent to be an informed one. Pre-test counselling, though crucial, is not a requirement under the law.

This is especially true when one surveys the practice of private doctors, be they of private clinics or hospitals. Through interviews conducted,[25] it has been found that private doctors have had the blood test for HIV antibodies carried out on patients without adhering to the procedure practiced in government hospitals as outlined above.

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24 Section 10 of the Prevention and Control of Infections Diseases Act 1988 (Act 342).

25 Interviews conducted during the period of field research from December 1991 to May 1992. These were of an informal nature with the assurance given to doctors concerned that no names nor figures would be mentioned.

In several cases, the blood test was incorporated in the pre-employment check-up which is paid for by the prospective employer. Patients were asked to sign a general consent form for the medical check-up. Most were not aware that HIV testing has been included. It is submitted that for the consent to be effective, the individual has to be informed of the fact that the HIV test would be included. Otherwise, it can be argued that the consent has been vitiated due to the lack of information or even deception.

In such a case, from the point of contract law, there are three parties to the contract of carrying out the pre-employment check-up - the prospective employer, the doctor and the patient/prospective employee. Since the prospective employer is the party bearing the costs of the procedure, it is privy to the contract. It is therefore not a breach of confidence for the doctor to reveal the results of the tests as the patient has given consent for the doctor to do so. It is a contractual arrangement which if an individual, takes exception to, there can only be one solution i.e. not to undergo the medical check-up.

This would rarely happen as the individual is in the less favourable situation of seeking employment and would be in no position to object. Various organisations and publications have noted that the requirement to undergo HIV test as part of the pre-employment medical check-up constitute discriminatory

practices which should be avoided eventhough legally, the employer is entitled to include the said test so long as it pays for it.

Where the result of the test is positive, the doctor is legally obliged to notify the Ministry of Health of the fact besides informing the prospective employer of the result of the whole medical check-up.[26] Being a doctor, it is of good medical practice for him to inform the patient of the result and render some counselling. If this is not possible, the patient would have to wait for the Ministry's machinery to take charge of the matter.

One possible issue that may arise is whether it is necessary for the doctor to inform the patient's country of origin of the patient's HIV status if the patient is a foreigner. At the moment, there is no such requirement in law but looking at the matter globally, there may arrive the time for the country of origin in addition to the World Health Organisation (WHO) to be so informed to enable a more comprehensive and cohesive plan of action to be formulated at a global level.

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26 Prevention and Control of Infectious Diseases Act 1988 (Act 342), section 10(2).

It is also not uncommon for such a test to be done upon request of the patient, with no questions asked or counselling rendered by the doctor. The result of the test would be conveyed to the patient subsequently. The rationale for such an approach is the fact that these are paying patients. It is an undeniable fact that some doctors do not notify the Ministry of Health regarding these cases.[27] This is despite the fact that it is a legal obligation on the part of doctors to inform the authorities concerned of the HIV positives.[28]

This fact is acknowledged by the Ministry of Health[29] which is at present seeking the cooperation of the Malaysian Medical Association in advising its members to heed the legal obligation. This is not only to enable accurate statistics to be kept but also to ensure that efforts to prevent and control the spread of the HIV infection and AIDS are effective. It would be of help to the Ministry's effort if doctors are made aware of the seriousness and importance of mandatory notification.

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27 Interviews conducted from Dec 1991 to May 1992. Supra footnote 18.

28 Supra, footnote 27.

29 Interview with Dr Jit Singh dated 9th July 1992.

Failure to report such cases to the Ministry of Health constitute a contravention of section 10 of the Prevention and Control of Infectious Diseases Act 1988 and amounts to an offence.[30] The penalty is stated under section 24 of the said Act:

> Section 24 General Penalty
>
> Any person guilty of an offence under this Act for which no specific penalty is provided shall be liable on conviction -
>
> (a) in respect of a first offence, to imprisonment for a term not exceeding two years or to a fine or to both;
>
> (b) in respect of a second or subsequent offence, to imprisonment not exceeding five years or to fine or to both;
>
> (c) in respect of a continuing offence, to a further fine not exceeding two hundred ringgit for every day during which such offence continues.

The doctor concerned is therefore liable to be imprisoned if found guilty.[31]

There would be no breach of confidentiality by doctors because there is an existing legal obligation to so notify

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30 Prevention and Control of Infectious Diseases Act 1988 (Act 342), section 10(5).

31 The offence however, may be compounded under section 25 of the said Act for a sum not exceeding one thousand ringgit.

under section 10 of the Prevention and Control of Infectious Diseases Act 1988.. To date, there has been no prosecution under section 10 of the said Act. As such, even though there is sanction behind the legal obligation, there is no enforcement.[32] In addition to the legal provisions discussed above, the Ministry of Health has been providing guidelines in its Plan of Action for the Prevention and Control of AIDS. Both the Malaysian Medical Council (MMC) and the Malaysian Medical Association rely on the guidelines stated by the Ministry of Health. The MMC has not issued any guidelines regarding AIDS and HIV to its members.[33]

Their British counterpart on the other hand have made statements and policies regarding testing for HIV antibodies. The General Medical Council has reiterated the necessity to obtain specific consent of the patient if HIV testing is required save in the most exceptional circumstances[34] i.e. where it is not possible to obtain consent and the health of others other than the patient is endangered.

The British Medical Association, the professional body of a large number of doctors, adopted a resolution in 1988 which states:

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32 Interview with Dr. Jit Singh of the Ministry of Health dated 9th July 1992.

33 Appendix 5.1 and 5.2 - letter to and from MMC.

34 General Medical Council, HIV Infection and AIDS, The Ethical Considerations, 1988.

> HIV testing should be performed only on clinical grounds and with the specific consent of the patient. There may be individual circumstances where a doctor believes that it is in the best interests of a particular patient it is necessary to depart from this general rule, but if the doctor does so he or she must be prepared to justify the action before the courts and the General Medical Council.[35]

It can be concluded that both the guideline and resolution of the GMC and BMA are consistent with the international standard of human rights which have been adopted by the World Health Organisation even though these statements, policies and guidelines have no legal sanctions.

Similarly, there is no legal sanctions backing the Malaysian Ministry of Health's Plan of Action For the Prevention And Control Of A.I.D.S. In addition, it is silent on the issue of whether a specific consent should be obtained prior to the taking of a blood sample from a patient for the purposes of conducting a HIV-antibody test. Nevertheless, the consent form used by government hospitals indicate that specific consent is required before an HIV-antibody test is carried out. These apply only to those who come to the hospitals on their own accord for the test. There are several

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35 AIDS: A GUIDE TO THE LAW, Dai Harris and Richard Haigh for the Terrence Higgins Trust, Routledge, London and New York, 1990.

exceptional situations whereby the HIV-antibody test may be carried out as a matter of routine screening and consent is not given much weight.

D. Screening under the Plan of Action

Although statements have been made to the effect that screening should not be carried out as it does not justify its purpose and the consequences which flows with it, the Ministry of Health has felt that it is necessary to do so in certain circumstances. Its general objective is to identify and screen people in the high risk groups such as homosexuals/bisexuals, prostitutes, intraveneous drug abusers, patients with other sexually transmitted diseases, tuberculosis in young/middle age persons, newly diagnosed mental patients and transfusions dependent patients.

The Ministry's specific objectives are:

1. To identify and register all those in the high risk groups.

2. To screen all those in the high risk groups for HIV antibodies.

3. To establish the incidence of HIV infection/ AIDS in the identified high risk groups.

4. To refer those confirmed positive to HIV for medical counselling.

5. To periodically review screening tests in terms of cost-effectiveness.

(1) Prisoners

The ongoing programme is for prisoners in all prisons in the country to be screened for HIV antibodies with priority given to those with high risk factors such as homosexuals, bisexuals, intravenous drug abusers and prostitutes. Ideally, screening is to be carried out once for each admission into prison and again before their release from prison. However, administrative co-ordination, lack of resources and manpower to carry out such an extensive programme have limited the screening process to a very large extent. The screening is carried out as and when manpower and resources are available. The problems of remand prisoners and the transfer of prisoners from one place to another has further compounded the difficulty of carrying out the screening process and keeping track of the movement of the prisoners. Nevertheless, a signed consent form[36] is obtained from prisoners.

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36 Appendix 4.3

There appears to be no difficulty in obtaining such a consent from the prisoners due to the fact that they would be given 'preferential' treatment such as a separate cell.[37] This is especially so in prisons where overcrowding occurs. This fact seem to negate, to a certain extent, the voluntariness of the consent given. This is because it was given in the light of the expected 'incentive'.

(2) Drug Rehabilitation Centres and Refuge Homes

Screening programmes are also carried out for those in drug rehabilitation centres and refuge homes.[38] Similar problems are encountered i.e. administrative co-ordination of the various agencies involved, lack of manpower, resources and time.

There is no guideline for the counselling or the obtaining of consent from those in the high risk groups who have been rounded up by the police e.g. drug addicts, prostitutes and homosexuals prior to the taking of blood

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37 Interview with Dr Zainol of the Pejabat Kesihatan, Dewan Bandaraya on the 19th October 1992.

38 See Appendix 6: Guidelines for the Screening of High Risk Groups for HIV Infection/AIDS, Appendix 11 of the Ministry of Health's Plan of Action for the Prevention and Control of AIDS 1988.

samples for the HIV-antibody tests. The plan of operation is left with the respective authorities i.e. police.[39]

(3) Sexually Transmitted Diseases/Tuberculosis/ mental patients and High Risk Groups seeking medical treatment

The Ministry of Health's guidelines regarding this group state that a signed consent is NOT necessary. Prudence on the part of the medical staff has been given precedence over the consent of the individual patient. The need to monitor these groups may also be one of the overriding factors. Whatever the actual reasons may be, in such a situation, it would appear that the HIV testing has been incorporated into the medical treatment sought by the patient. Thus the doctor and health care workers have been given a 'blanket approval' insofar as the whole scheme of treatment is concerned.

This may be questioned as breaching the basic human rights of the patients. However, the realities and practicalities of human and financial resources available to ensure a practical solution to the prevention and control of HIV infection and AIDS in a developing country like

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39 Due to restraint of time and the scope of the thesis, field work covering the prisons, drug rehabilitation centres, refuge homes, the screening by the police (anti-narcotic and anti-vice section) and high risk groups seeking medical treatment have been left out. Subsequent studies should be carried out to explore these aspects.

Malaysia has to be given due weight. One also has to recognise that AIDS threatens human life. The right to life is a fundamental right and the government has an obligation to protect the lives of its citizens. Thus, certain measures which breach the right of the individual, may be justifiable if one takes into consideration the protection of members of the public. The protection of public health is recognised to be among the legitimate grounds for the restriction of human rights. Limitations placed upon privacy, freedom of movement or individual liberty are sometimes dictated by the need to protect public health.

However, the public health rationale should not be the sole overriding factor in such cases. International human rights law ought not be just swept aside. The WHO has declared on many occasions that such restrictions are not necessary in the case of HIV/AIDS, that there is no public health rationale for the imposition of quarantine, isolation or compulsory screening or testing. Although in Malaysia, quarantine and isolation are based on clinical diagnosis rather than automatically imposed upon being confirmed HIV positive, compulsory screening and testing are being practised as mentioned in earlier paragraphs.

The controversy surrounding the testing of HIV antibodies can be traced to several factors. Firstly, the ELISA test is not 100 percent reliable. There is

approximately 10 percent incidence of false results.[40] This can be remedied to a certain extent by confirming positive tests by the more expensive but less fallible supplemental test like the Western Blot test which has an approximate of 1 per cent false positives. Secondly, there is a period where the tests would not be accurate and would result in a false negative test. This is within the period of nine to ten weeks after infection where it is most veremic i.e. not sufficient antibodies to be detected and when there are no antibodies left. These are called the 'window period'. A test during the window period would result in a negative result even though that person is HIV infected. It is thus a false negative result. Finally, the test is relevant only in respect of the moment that individual is tested. The result of the test cannot guarantee or predict that the person would be HIV/AIDS-free in the near future. It is therefore not useful as a prognostic tool.

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40 Confirmed by Dr. Vijayamalar of the NARL. Interview dated 21st December 1992.

CHAPTER III

IMPACT OF TEST

The test for HIV antibody leaves an impact on various aspects of that person's life. Aside from the emotional and psychological impact on the patient himself, it may affect the patient in specific areas of law. These include employment/ labour and insurance. Subsequent paragraphs will give the background of the law in Malaysia before proceeding to discuss the issues that may arise in the light of the various consequences and implications of the test for HIV-antibodies.

A. Employment

In Malaysia, a variety of legislation exists affecting industrial relations. The Industrial Relations Act 1967[1] governs the relations between employers, employees and their trade unions. Relations between individual employers and their individual employees are governed mainly by the Employment Act 1955.[2] Factories and Machinery Act 1967[3] governs the health

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1 Act 177.

2 Act 165.

3 Act 139.

and safety of workers. Welfare and the well-being of employees are governed by a few statutes e.g. the Employees Social Security Act 1969.[4] These are only some of the legislation affecting the labour law in Malaysia. Common law is relied on in many instances where the statutes are silent on a particular point of law. This is made possible by section 3 and 5 of the Civil Law Act 1956.[5]

Furthermore, the categories of employees covered by the Employment Act are limited. This is listed under the First Schedule of the Employment Act 1955 and would include those that fall under section 2A(3) of the said Act.[6] The Act thus covers employees under the categories listed below:

1. any person, irrespective of his occupation, who has entered into a contract of service with an employer under which such person's wages do not exceed one thousand two hundred and fifty ringgit ($1,250) per month; or

2. any person whose wages exceed one thousand two hundred and fifty ringgit ($1,250) per month and if he is engaged in manual labour including such

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4 Act 4.

5 Act 67.

6 Section 2(1), Employment Act 1955.

labour as an artisan or apprentice. Where it is only partly of manual labour, such a person is not considered as manual labour unless the time spent on manual labour in any one wage period exceeds one-half of his total working time; or

3. any person engaged in operation or maintenance of mechanically propelled vehicle for the transport of passengers or goods or for commercial purposes; or

4. any person supervising or overseeing other employees engaged in manual labour, employed by the same employer; or

5. any person engaged as a domestic servant; or

6. any person engaged in any capacity in any vessel registered in Malaysia and is not an officer certificated under the Merchant Shipping Acts of the United Kingdom (as amended from time to time) or is not a holder of an officer certificated under the local Merchant Shipping Ordinance 1952, or has not entered into an agreement under the Merchant Shipping Ordinance 1952; or

7. any person or class of persons whose employment has been approved by the order of the Minister, subject to such conditions as he may deem fit to impose.

There are significant number of employees that are not covered by the Employment Act 1955. They include government servants who are governed by their contracts of service and more importantly the general orders issued by the Jabatan Perkhidmatan Awam Malaysia. Those who earn more than one thousand, two hundred fifty ($1,250) per month are also excluded (except manual labour). A majority of them would be professionals. For this group of employees, they would be governed strictly by their contracts of service under contract law.[7] They are presumed to be in a better position to negotiate their terms prior to their joining a particular firm as an employee.

In terms of employment, although HIV infection should not affect the working environment so long as the employee is still fit to work and poses no danger to the other co-employees, it is undeniable that problems do face both the employer and employee. This is mainly due to the lack of understanding of the infection and its transmission. An

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7 Contracts Act 1950 (Act 136).

employer may be faced with the fear of other employees of being infected which most often would lead to the infected employee being isolated from the rest. In certain working environment such as that of doctors, nurses and other health care workers, the fear is of being infected at work due to their nature of work.

The legal issues that may arise include the testing for HIV antibodies, confidentiality and discrimination. These issues have to be analysed with the Malaysian employment law as the background.

Employment law is based on the contract between the employer and employee. It allows the employer to determine the conditions of labour. This is however, subject to the minimum protection and rights afforded to the individual employee by legislation.

The following discussion is based on the Employment Act 1955 and common law unless otherwise specified.

1. Terms and Conditions of Employment

An employee is entitled to know the terms and conditions of his employment. Those provided for in the contract of service

would be the expressed terms. They include payment of wages, entitlement to leave, disciplinary rules, termination of contract and the job title.

There are also implied terms and duties which are unwritten. Terms may be implied by law or custom and practice. It may arise out of the very nature of the contract of employment e.g. good faith. It may also be by reason of the circumstances surrounding the creation of the contract. An important one is that of mutual duty of trust and confidence. The behaviour of both the employer and employee must be based on mutual trust and confidence due to the unique nature of the contractual relationship. A breakdown or breach in the mutual trust and confidence is sufficient justification for an employee to resign.

In Woods v W.M. Car Services (Peterborough) Ltd[8], Lord Denning stated:[9]

> It is the duty of the employer to be good and considerate to his servants ... Just as a servant must be good and faithful, so an employer must be good and considerate. Just as in the old days an employee could be guilty of misconduct justifying his dismissal, so in modern times an employer can be guilty of misconduct justifying the employee in leaving at once without notice.

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8 [1982] IRLR 413.

9 Ibid, at p 415.

The principles governing the implied term of mutual trust and confidence was summarised by Glidewell LJ in Lewis v Motorworld Garages Ltd.[10] There are normally implied in a contract of employment mutual rights and obligations of trust and confidence.

In Robinson v Crompton Parkinson Ltd,[11] Kilner Brown J held that in a contract of employment there is an implied term that the employer will not do anything which will undermine mutual trust and confidence. The appellant in that case was accused of theft by his employers and prosecuted by the police. He gave the employers opportunity to apologise for their actions. When no apology was forthcoming, he resigned. He was subsequently found to have been unfairly and improperly accused of the offence and was acquitted.

A breach of this implied term may justify the employee in leaving and claiming that he has been constructively dismissed.[12] The breach of this implied term may consist of a series of actions on the part of the employer which cumulatively amount to a breach of the term, though each individual incident may not do so.[13]

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10 [1985] IRLR 465.

11 [1978] IRLR 61.

12 See Post Office v Roberts [1980] IRLR 347; Woods v WM Car Services Ltd [1981] IRLR 173, per Browns Wilkinson J at 350.

13 Woods v WM Car Services Ltd [1981] IRLR 173.

Constructive dismissal refers to a situation where the resignation of an employee was in such a circumstance that he is entitled to terminate his contract without notice because of his employer's conduct. Although the employee resigns, it is the employer's conduct which constitutes a repudiation of the contract, and the employee accepts that repudiation by resigning. The question as to whether an employee is entitled to do so is to be answered in accordance to the rules of contract. This was affirmed by the Court of Appeal in Western Excavating (ECC) Ltd v Sharp.[14] Lord Denning MR laid it down as such:

> If the employer is guilty of conduct which is a significant breach going to the root of the contract of employment,[15] or which shows that the employer no longer intends to be bound by one or more of the essential terms of contract, then the employee is entitled to treat himself as discharged from any further performance ... [T]he conduct must ... be sufficiently serious to entitle him to leave at once...[16]

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14 [1978] ICR 221.

15 Emphasis is mine.

16 [1978] ICR 221 at p 266.

On the other hand, it would be unfair to force the employer to continue employing a person in whom he no longer has the trust and confidence. It has been shown however, where employers are given accurate information and education on AIDS and HIV transmission, chances of such loss of trust and confidence are greatly minimised.

It is submitted that employers are not free to require their employees to take the HIV-antibody test. Unless employees are unfit to work, there is no reasonable cause to require them to take the said test. This is as opposed to the argument that there is no reason whatsoever why an employer cannot require their employees to undergo certain specific medical tests in addition to the usual annual medical check-up so long as the costs of such tests are borne by the employer. Although presently there is no specific legal provision to say that an employer cannot do so, in the light of the stand taken by the WHO as acknowledged by the Ministry of Health that HIV-antibody test requires the consent of the individual in addition to the fact that it does not reflect the fitness of that individual for the near future, it is submitted that such a request on the part of the employer would have an adverse effect as it would undermine the trust and confidence which are essential elements in the employer-employee relationship. As discussed earlier the breach of mutual trust and confidence may be sufficient to entitle an employee to resign and claim constructive dismissal.

In Bliss v South East Thames Regional Health Authority[17], the employer had required the employee, a consultant orthopaedic surgeon at Medway Hospital to undergo a psychiatric examination. The surgeon was suspended from his post when he refused to do so and was refused access to the hospital.

The Court of Appeal held that there is no general power in an employer to require employees to undergo psychiatric examination. The implied term of the contract that the employer was entitled to require the surgeon to undergo a medical examination was only if they had reasonable ground for believing he might be suffering from physical or mental disability which might cause harm to patients or adversely affect the quality of their treatment. Since the enquiry by the committee concluded that the problem was only a severe degree of breakdown of personal relationships in the department and found no mental or pathological illness on the part of the surgeon, the employer had no right to require the plaintiff to submit to a psychiatric examination.

By so requiring, they had breached the implied term that they would not without reasonable cause conduct themselves in a manner likely to damage or destroy the relationship of trust and confidence between the parties as employer and employee. Dillion LJ elaborated:

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17 [1985] IRLR 308.

> ... if ever there was a breach of such a term going to the root of the contract, it was this. It would be difficult, in this particular area of employment law, to think of anything more calculated or likely to destroy the relationship of confidence and trust which ought to exist between employer and employee than, without reasonable cause, to require a consultant surgeon to undergo a medical, which was correctly understood to mean a psychiatric examination, and to suspend him from the hospital on his refusing to do so.[18]

There is thus no necessity for employers to make it a general policy to require a selected group or all of its employees to take the HIV-antibody test as it has no bearing on their fitness to work. The only exception is when an employee suffers certain symptoms that require confirmation of his HIV status to enable the employer to assess his fitness to work. Further, if screening of employees for HIV infection is made a policy, the costs to carry out such a policy would be quite substantial. The Ministry of Health is discouraging employers from including HIV-antibody test in the usual medical check-up by imposing a higher charge to carry out such tests.[19] Although this would not entirely deter employers from insisting that the test be included, it reflects the policy of the Ministry of Health which is in line with the various resolutions adopted by the WHO. In the light of facts that

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18 Ibid at p 314 and 315.

19 Interview with Dr Jit Singh of the Ministry of Health on 9th July 1992.

such tests are not 100% accurate, reflects the HIV-status at only that particular point of time and is no guarantee that all the HIV-negative employees would remain so in the future, it would be wiser for employers to not include the test in the annual medical check-up as it would not be beneficial to the organisation in the long run. It would also create suspicion and disharmony amongst employees. The widespread lack of understanding and knowledge on HIV infection and AIDS in all probabilities may create unnecessary problems in the working environment which might lead to legal actions later on.

2. The Common Law Duty of Confidence

In addition to the implied term of mutual trust and confidence which exist in an employer-employee relationship, there is the common law duty of confidence. This duty to keep secret all information imparted in a trusting relationship goes beyond the simple duty of employment. An employer, being in the unique position of being able to require and keep personal information and data of the employee, owes a duty of confidence to that employee. The duty of confidence arises whenever information is imparted by one person to another, either expressly in confidence or in circumstances where such confidentiality is implicit. One such information would be the HIV seropositivity of the employee.

Although the duty is not absolute,[20] the courts have shown themselves willing to preserve the confidentiality of medical records and in particular, information about AIDS. In X v Y[21], the employer, a health authority, sought an injunction to restrain the defendants, a reporter and the owner of a national newspaper from publishing information relating to the fact that two doctors employed by the plaintiff were still practising although they have been diagnosed with AIDS. The information was leaked to the defendant by one or more employees of the plaintiff. This was a breach of confidentiality.

The defendants' argument that it was in the public interest to publish the information of the two identified practising doctors who are being treated for AIDS was rejected by the court. Rose J held that the public interest in preserving the confidentiality of hospital records identifying actual or potential AIDS sufferers outweighed the public interest in the freedom of the press to publish such information. The learned judge was of the opinion, after hearing evidence from medical experts, that victims of the disease ought not to be deterred by fear of discovery from

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20 Public interest and statutory provision to the contrary would override the confidentiality.

21 [1988] 2 All ER 648.

going to hospital for treatment. Further, free and informed public debate about AIDS could take place without the necessity of breaching the confidence of such information. The plaintiff was held to be entitled to a permanent injunction restraining the defendants from publishing that information in any form.

Although in the case stated the plaintiff i.e. the hospital authority is under a statutory duty to ensure that any information capable of identifying patients examined or treated for AIDS shall not be disclosed except to a medical practitioner (or a person under his direction) in connection with or for the purpose of treatment, or prevention of the spread of the disease, it is submitted that an employer-employee situation would similarly warrant a duty of confidence on the part of the employer. This ought to encompass information as to the employees' HIV seropositivity. The relationship is such that if any such information is given by the employee to the employer, circumstances are such that confidentiality is implicit.

If it was divulged expressly in confidence, then there is no doubt that such a duty exists. In Stephens v Avery[22], the relationship was that of close friends. The confidential information relates to the sexual conduct of the plaintiff.

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22 [1988] 2 All ER 477.

There was an understanding and agreement that the knowledge gained by the first defendant was entirely secret and the subject of an absolute obligation of confidence. The first defendant revealed the information to the second and third defendants, the proprietor and publisher of a newspaper. The court held that such information could be the subject of a legally enforceable duty of confidence if it would be unconscionable for the person who had received information on the express basis that it was confidential to subsequently reveal it to another.

Sir Nicolas Browne-Wilkinson VC referred to the three requirements for a case of breach of confidence to succeed.[23] Firstly, the information itself must have the necessary quality of confidence about it. Secondly, that information must have been imparted in circumstances importing an obligation of confidence. Finally, there must be an unauthorised use of that information to the detriment of the party communicating it. Rose J in X v Y[24] however, was of the opinion that detriment in the use of the information is not a necessary precondition to injunctive relief.

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23 Saltman Engineering Co Ltd v Campbell Engineering Co Ltd (1948) [1963] 3 All ER 413, CA; Coco v AN Clark (Engineers) Ltd [1969] RPC 41.

24 [1988] 2 All ER 648 at p 657.

Therefore, where an employee's seropositivity is made known to the employer, either through the company's panel of doctors or when the employee himself informs the employer, such information would be within the group of information which are confidential. In the former, medical details will certainly be confidential, being obtained through professional and legal duty of confidence. Although there are three parties i.e. the doctor, employer and employee, such information remains confidential vis-a-vis others. Thus, the doctor, through the contractual obligation may inform the employer, who is responsible for the payment of the doctor's services, of the employee's seropositivity. Both the doctor and the employer are bound to keep that information confidential.

If such information was passed on to another party by either the doctor or the employer, it would constitute a breach of confidence. However, in the case of doctors, since there is a statutory obligation to notify the health authority of all forms of HIV infection, such notification is not a breach of the duty of confidence. The notification is required under section 10(2) of the Prevention and Control of Infectious Diseases Act, 1988. Other than the health authority, all others who are not concerned with the health care are to be excluded as the duty of confidence remains.

Should the duty to inform the respective authority regarding the HIV infection of a person be extended to an employer who has such a knowledge? This is in the light of the practice of some employers who are beginning to include HIV testing as part of the pre-employment medical check-up and annual medical check-up of their employees. This duty may be found in section 10(1) of the Prevention and Control of Infectious Diseases Act 1988[25] which states inter alia,

> ... every person in charge of, or in the company of, and every person not being a medical practitioner attending on, any person suffering from or who has died of an infectious disease shall, upon becoming aware of the existence of such disease, with the least practicable delay notify the officer in charge of the nearest district health office or government health facility or police station or notify the nearest village head of the existence of such disease.

It is submitted that section 10(1) of the said Act covers an employer, being a person 'in charge of' the infected employee. With the said practice of including HIV-testing in the medical check-up, it is submitted that the 'freedom' or 'right' of the employer to so require a test should be coupled with the statutory duty to inform the respective authorities as laid down in section 10(1) of the said Act.

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25 Act 342.

3. Health and Safety

The only statutory provisions regarding the health and safety of workers or employees is under the Factories and Machinery Act 1967.[26] It is thus limited to the application of the Act only.[27] Section 10 of the Act relates to the physical safety aspect of the working place. Provisions relating to health fall under section 22 of the Act which deal specifically with physical aspects such as cleanliness of the working place, number of persons employed at any one time in a specific working area, ventilation, temperature, lighting and sanitary facilities.[28] Section 22(3) of the Act is concerned only with notifiable industrial diseases listed under the Third Schedule.[29] The requirement for medical examination is limited to those diseases.

It appears that HIV infection and AIDS are not included in the Third Schedule of Factories and Machinery Act 1967.[30] Therefore as it is, there is no legal basis to require

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26 Act 139 which came into force on 1st February 1970. Operation of the Act in Sabah & Sarawak has been suspended - PU(B) 6/70.

27 Definition of the term 'factory' is in Appendix 7.

28 Section 10 of the Factories and Machinery Act 1967 is in Appendix 8.

29 Section 22 is in Appendix 9.

30 Third Schedule is Appendix 10.

medical examination to determine the seropositivity of an employee. It cannot be said that HIV/AIDS poses a threat to the health and safety of other co-employees.

4. Termination/Dismissal

The only termination of contract of service or dismissal of an employee allowed under the law are as provided under the Employment Act 1955[31] and the Industrial Relations Act 1967.[32] These include normal termination,[33] termination by notice,[34] termination without notice[35] and termination for special reasons[36] under the Employment Act 1955 whereas the Industrial Relations Act 1967 requires that a workman be dismissed only with just cause or excuse by his employer.[37]

Section 11 of the Employment Act 1955 provides that a contract of service for a specified period of time or for the performance of a specified piece of work terminates when the period has expired or the work completed. This constitute a

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31 Act 265.

32 Act 177.

33 Employment Act 1955, section 11.

34 Ibid, section 12.

35 Ibid, section 13.

36 Ibid, section 14.

37 Industrial Relations Act 1967, section 20.

normal termination. There would be situations whereby either party would like to terminate such contract prior to the completion of the period or work. In such a case, section 12 requires that a written notice be given to the other party of the intention to terminate the contract of service. The length of notice are as stated in the contract itself. Otherwise, it is provided for in section 12(2)(a) to (c).

Where the termination is wholly or mainly due to certain circumstances stated under section 12(3)(a) to (f), the employee is entitled to a notice of termination of service. These include the fact that the employer has ceased or intends to cease to carry on the business for the purposes of which the employee was employed.

Notice can be dispensed with by the payment to the other party an indemnity of the sum equal to the amount of wages which would have accrued to the employee during the term of such notice or the unexpired term of such a notice.[38] A wilful breach by one party of a condition of the contract of service entitle the other party to terminate the contract of service without notice.[39] This refers to section 15 i.e. where an employer fails to pay wages in accordance with Part III and where an employee was continuously absent from work

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38 Employment Act 1955, section 13(1).

39 Ibid, section 13(2).

for more than two consecutive working days without prior leave. The employee must have a reasonable excuse for his absence and has informed or attempted to inform his employer of such excuse either prior to the absence or at the earliest opportunity during the absence.

Other than the above, only on the grounds of misconduct inconsistent with the fulfilment of the express or implied conditions of service and after due inquiry, is an employer allowed to terminate the contract. The action may be dismissal without notice, downgrading the employee or suspending him from work without payment for a period not exceeding one week.[40]

On the other hand, an employee may terminate his contract of service with his employer without notice in a situation where he or his dependants are immediately threatened by danger to the person by violence or disease such as those which the employee did not undertake to run under his contract.[41] This provision in law allows the employee to terminate his contract without notice if such an occasion arises. Although this may be used by co-employees who fear HIV infection at the place of work where an employee is HIV-

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40 Ibid, section 14(1).

41 Ibid, section 14(3).

positive, this can be easily countered by the proper management and counselling session to educate the co-employees of the risks of HIV infection and its modes of transmission.

Normal social and work contact with an infected person is safe for both colleagues and the public.[42] The only groups with occupational risks include doctors, dentists, nurses, laboratory workers, those responsible for the disposal of bodies, first-aiders and health-care workers. The practise of universal precautions of hygiene and safety will minimise risks of exposure when dealing with infected body fluids. They include the use of plastic disposable gloves and bleach to deal with spillages.

5. Conclusion

In our attempts to deal with the numerous problems that may arise in a workplace where the employee(s) has HIV infection or AIDS, it is helpful to consider policy considerations. The World Health Organization in association with International Labour Office have, under the Global Programme on AIDS come up with a Statement From The Consultation On AIDS And The Workplace.[43]

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42 Statement by the Health and Safety Executive of the United Kingdom formed under the Health and Safety At Work Act 1974.

43 The consultation was held in Geneva from 17-29 June 1988.

It was acknowledged that protection of human rights and dignity of HIV-infected persons, including persons with AIDS, is essential to the prevention and control of HIV/AIDS. It was agreed upon that workers with HIV infection who are healthy should be treated the same as any other worker. HIV-related illness, including AIDS, should be treated the same as any other illness. A supportive occupational setting ought to be provided to enable them to contribute their creativity and productivity as it enhances their physical and mental well-being to continue working. There is no valid reason why they should not be allowed to work.

The World Health Assembly resolution entitled 'Avoidance of discrimination in relation to HIV-infected people and people with AIDS' urges Member States:

> ... (1) to foster a spirit of under- standing and compassion for HIV- infected people and people with AIDS...;
>
> (2) to protect the human rights and dignity of HIV-infected people and people with AIDS ... and to avoid discriminatory action against, and stigmatization of them in the provision of services, employment and travel;
>
> (3) to ensure confidentiality of HIV testing and to promote the availability of confidential counselling and other support services ...

The lack of specific local legislation dealing with HIV/AIDS in the employment sector do not warrant or condone stigmatization and discrimination in a workplace. Existing social and legal context together with our national health policies should be geared towards the prevention and control of HIV/AIDS. The compliance and consideration of such policies as stated above would enhance the possibilities of success in our efforts to prevent and control the spread of HIV/AIDS. Thus, although local legislation do not provide for such a situation as HIV/AIDS, existing legal provisions should be interpreted and applied in accordance with the policies agreed upon by the WHO and the ILO.

B. Issue of Confidentiality

The Ministry of Health's Plan of Action For the Prevention and Control of AIDS define HIV-infected persons as including all individuals, regardless of their clinial status, who are infected with the virus. These are as shown by positive serological tests, usually enzyme-linked Immunosorbent assay (ELISA) and the particle agglutination test. The results are to be confirmed by immunoblot (Western blot) assay, or line immunoassay. The diagnosis of HIV Infection/AIDS must be based on clinical and laboratory evidences.

Due to the serious consequences and implications of the diagnosis, it is crucial that the person tested be given pre and post-test counselling. Adverse reactions may come from any or all sectors including family members and friends. Ostracism of not only the infected but also those in the family have occurred in Malaysia.

A 33 years old housewife who died of AIDS in April 1990 was an outcast to her own family members throughout her illness.[44] The family members of a ten year old haemophiliac child with AIDS whose case was highly publicised also had to endure public rejection and fear to the extreme such as refusal to sell noodles to the child's mother for fear of infection via the utensils used.[45] Even when her own utensil is used, the noddle seller refused. Such paranoia of getting infected is widespread due to lack of information, knowledge and understanding of the HIV transmission and AIDS.

1. Confidentiality

Confidentiality is therefore a crucial factor. It is well-established that a doctor owes a duty to the patient to keep the information regarding the patient confidential although it is accepted that this duty is not absolute.

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44 The Star, 24 Dec 1991.

45 The Star, 22 Sept 1991.

The doctor-patient relationship is such that it gives rise to a duty on the part of the doctor to respect the confidence of his patients. There is a general common law duty of confidentiality imposed on the doctor. For the duty of confidentiality to arise, several elements must be satisfied. Firstly, the nature of the relationship is such that one party places his trust on the other as in a doctor-patient relationship. The doctor-patient relationship was cited as a classic example in Stephens v Avery.[46] Secondly, the nature of the information itself must be of a confidential nature. Where the information itself is in fact known to a substantial number of people, it ceases to be capable of protection as confidential. This was reflected by Sir John Donaldson MR in AG v Guardian Newspapers Ltd (No 2)[47] where he stated:[48]

> As a general proposition, that which has no character of confidentiality because it has already been communicated to the world, i.e., made generally available to the relevant public, cannot thereafter be subjected to a right of confidentiality ... However, this will not necessarily be the case if the information has previously only been disclosed to a limited part of that public. It is a question of degree ...

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46 [1988] 2 All ER 477, at p 482.

47 [1988] 2 WLR 805.

48 Ibid, at p 868.

This was reiterated by Bingham LJ:[49]

> The information must not be 'public knowledge' (Seager v Copydex Lte [1967] 1 WLR 923 at 931, per Lord Denning MR), nor in the public domain: Woodward v Hutchins [1977] 2 All ER 751 at 755, per Lord Denning MR, to be confidential information must have what Francis Gurry recently called the basic attribute of inaccessibility: see Gurry, Breach of Confidence (1984) at p 70.

Finally, circumstances under which such information was disclosed must be such that it imports an obligation of confidence. This is closely linked to the first element. In the medical context, these two elements go hand in hand.

In Hunter v Mann[50], it was accepted that:[51]

> ... the doctor is under a duty not to [voluntarily] disclose, without the consent of the patient, information which he, the doctor, has gained in his professional capacity.

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49 Ibid, at p 903.

50 [1974] QB 767.

51 Ibid, per Boreham J at p 772.

This duty is, however, subject to exceptions. Firstly, where the patient gives his consent to the disclosure and secondly, where there is a statutory obligation to disclose the information as was in this case. Clear statutory language overriding the duty of confidence would prevail over the general duty of confidence. Here, the doctor was statutorily obliged to divulge the information which would lead to the identification of the driver of a stolen motor vehicle alleged to be guilty of the offence of driving in a manner dangerous to the public. The doctor had attended to a man and a girl who had been involved in a motor vehicle accident in the evening after the accident. The statutory duty to disclose the names and addresses of his patients was under section 168(2) of the Road Traffic Act 1972.

Another situation whereby a disclosure is favoured is when public interest overrides the duty of confidentiality.

In the recent case of W v Egdell,[52] a doctor's duty to his patient as opposed to the doctor's duty to the public regarding the disclosure of confidential information contained in the report on the patient's mental condition was discussed. The Court of Appeal had no difficulty in accepting the existence of an obligation of confidentiality between psychiatrist and his subject. The issue was whether that duty of confidence is subordinate to the duty owed to the public.

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52 [1990] 1 All ER 835.

The patient, W, was detained in a secure hospital without limit of time as a potential threat to public safety after he shot and killed five people and wounded two others. He applied, after ten years in detention, to a mental health review tribunal to be discharged or transferred to a regional secure unit with a view of his eventual discharge. His application was opposed by the Secretary of State but was supported by his medical officer. To build up his case, a consultant psychiatrist, E, was engaged to examine W and prepare an independent report on his mental condition. In his report, E strongly opposed to the transfer applied for and recommended further tests and treatment of W. Attention was also given to W's long-standing interest in firearms and explosives. The report was sent to W's solicitors in the belief that it would be placed before the tribunal. Due to its content, W through his solicitors withdrew the application. When E learnt of this, he contacted the medical director of the hospital. After discussing the case, it was agreed that the hospital should receive a copy of the report in the interests of W's further treatment. A copy was also sent to the Secretary of State, at E's prompting, who in turn forwarded the report to the tribunal.

W, upon discovering that the report had been disclosed, issued a writ against E and the recepients of the report seeking (i) an injunction to restrain them from using or

disclosing the report, (ii) delivery up of all the copies of the report and (iii) damages for breach of the duty of confidence.

The judge at first instance[53] held that the duty of confidentiality owed by E to W as his patient was subordinate to E's public duty to disclose the results of his examination to the relevant authorities because such a disclosure was necessary to ensure that the authorities were fully informed about W's mental condition when making decisions concerning his future. W's claim was accordingly dismissed. The decision was affirmed by the Court of Appeal.

The Court was in favour of disclosure because of the seriousness of the killings committed by W. An informed judgment of W's mental condition was crucial to decisions leading to his release. Since E's report had highly relevant information regarding W's condition, E's passing it on to the relevant authorities was justified as it concerned public safety.

These qualifications arise for the reason clearly given by Lord Goff in AG v Guardian Newspapers Ltd (No 2),[54] quoted by Scott J[55]:

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53 Scott J, [1989] 1 All ER 1089.

54 [1988] 3 All ER 545, at p 659.

55 [1989] 1 All ER 1089 at p 1102.

> ... although the basis of the law's protection of confidence is that there is a public interest that confidences should be preserved and protected by the law, nevertheless that public interest may be outweighed by some other countervailing public interest which favours disclosure ... It is this limiting principle which may require a court to carry out a balancing operation, weighing the public interest in maintaining confidence against a counter-vailing public interest favouring disclosure.

Thus, it is undeniable that whilst there is a duty of confidence owed by a doctor to his patient, this duty is not absolute. In carrying out treatment, a doctor would acquire personal information of his/her patients and it is such information that he/she is entrusted to keep confidential.

When a person is being informed of the fact that he/she is HIV-antibody positive, there are various reactions to such news. It may range from shock, disbelief, anger, guilt, fear, self-pity, shame and resentment to resignation to fate.[56] The personality, background and education level of the person concerned would influence the type of reaction a person may experience. Having an HIV antibody test is undoubtedly a psychologically distressing experience. It is submitted that information regarding the HIV status of the patient falls

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56 Interviews with counsellor at Universiti Hospital conducted during field research from December 1991 to May 1992.

within the scope of information which is subject to the duty of confidence as it arise within the context of a doctor-patient relationship and the nature or character of the information is such that it is confidential. This is further strengthened by the fact that the disclosure of the information would have far-reaching effects - legally, socially and economically, on the patient. That being so, the seropositivity of the patient is confidential.

The moral content of the duty of confidence is considerable. Ethical requirements of the medical profession can be found in a number of sources. The Hippocratic Oath states that:

> " What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account must be spread abroad, I will keep to myself holding such things shameful to be spoken about."

whereas the Declaration of Geneva put it down as:

> " I will respect the secrets which are confided in me even after the patient has died."

Thus, ethically, the confidentiality stretches to even after a patient has passed away. This sacred obligation of the doctor arose out of the unique doctor-patient relationship of which trust is a crucial factor. In today's context, this is limited by the requirement of law for the doctor to state the cause of death on the death certificate. This duty is further reaffirmed in the International Code of Medical Ethics pertaining to the duties of doctors in general. It states inter alia that

> " A Doctor shall preserve absolute secrecy on all he knows about his patients because of the confidence entrusted in him."[57]

The ethical duty of confidence under the Hippocratic Oath, Declaration of Geneva and the International Code of Medical Ethics however, has no legal binding effect, being basically a code of conduct for the medical profession.

Besides the above, the British General Medical Council's 'Blue Book' on professional conduct and discipline, 'Advice on Standards of Professional Conduct and of Medical Ethics' can also be referred to. Although as stated by Scott J in W v Egdell and others[58]:

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57 Emphasis is mine.

58 [1989] 1 All ER 1089, at p 1103.

> These rules do not provide a definitive answer to the question raised ... as to the breadth of the duty of confidence ... They seem to me valuable, however, in showing the approach of the General Medical Council to the breadth of the doctor/patient duty of confidence.

These rules do not themselves have statutory authority, being merely advice and guidelines to doctors in their professional conduct and discipline. Nevertheless, these rules are referred to by the General Medical Council in exercising its disciplinary jurisdiction in pursuance of the provisions of the Medical Act 1983.

Under the heading 'Professional Confidence', rr 79 to 82 provide as follows:

> 79. The following guidance is given on the principles which should govern the confidentiality of information relating to patients.
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> 80. It is a doctor's duty, except in the cases mentioned below, strictly to observe the rule of professional secrecy by refraining from disclosing voluntarily to any third party information about a patient which he has learnt directly or indirectly in his professional capacity as a registered medical practitioner. The death of the patient does ot absolve the doctor from this obligation.
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> 81. The circumstances where exceptions to the rule may be permitted are as follows:

(a) If the patient or his legal adviser gives written and valid consent, information to which the consent refers may be disclosed.

(b) Confidential information may be shared with other registered medical practitioners who participate in or assume responsibility for clinical management of the patient. To the extent that the doctor deems it necessary for the performance of their particualr duties, confidential information may also be shared with other persons (nurses and other health care professionals) who are assisting and collaborating with the doctor in his professional relationship with the patient. It is the doctor's responsibility to ensure that such individuals appreciate that the information is being imparted in strict professional confidence.

(c) If in particular circumstances the doctor believes it undesirable on medical grounds to seek the patient's consent, information regarding the patient's health may sometimes be given in confidence to a close relative or person in a similar relationship to the patient. However, this guidance is qualified in paragraphs 83-85 below.

(d) If in the doctor's opinion disclosure of information to a third party other than a relative would be in the best interests of the patient, it is the doctor's duty to make every reasonable effort to persuade the patient to allow the information to be given. If the patient still refuses then only in exceptional cases should the doctor feel entitled to disregard his refusal.

(e) Information may be disclosed to the appropriate authority in order to satisfy a specific statutory requirement, such as notification of an infectious disease.

(f) If a doctor is directed to disclose information by a judge or other presiding officer of a court before whom he is appearing to give evidence, information may at that stage be disclosed. Similarly, a doctor may disclose information when he has been summoned by authority of a court in Scotland, or under the powers of a Procurator-Fiscal in Scotland to investigate sudden, suspicious or unexplained deaths, and appears to give evidence before a Procurator-Fiscal. Information may also be disclosed to a coroner or his nominated representative to the extent necessary to enable the coroner to determine whether an inquest should be held. But where litigation is in prospect, unless the patient has consented to disclosure or a formal court order has been made for disclosure, information should not be disclosed merely in response to demands from other persons such as another party's solicitor or an official of the court.

(g) Rarely, disclosure may be justified on the ground that it is in the public interest which, in certain circumstances such as, for example, investigation by the police of a grave or very serious crime, might override the doctor's duty to maintain his patient's confidence.

(h) Information may also be disclosed if necessary for the purpose of a medical research project which has been approved by a recognised ethical committee.

82. Whatever the circumstances, a doctor must always be prepared to justify his action if he has disclosed confidential information. If a doctor is in doubt whether any of the exceptions mentioned above would justify him in disclosing information in a particular situation he will be wise to seek advice from a medical defence society or professional association.

Doctors in Malaysia are governed by the Code of Professional Conduct which has been adopted by the Malaysian Medical Council (MMC).[60] This is in addition to the Declaration of Geneva which is endorsed by the MMC. The MMC exercises disciplinary jurisdiction over registered medical practitioners as conferred by section 29, Medical Act, 1971.[61] One of the grounds under which this jurisdiction may be exercised is where the registered person has been guilty of 'infamous conduct in any professional respect.'[62] This would expose the doctor to a wide range of potential professional penalties.[63]

The term 'infamous conduct in any professional respect' is not conclusively defined. However, the MMC has listed down several forms of infamous conduct which includes inter alia, abuse of professional privileges and skills. Trust and confidence are recognised as crucial to good medical practice and the doctor-patient relationship. Practitioners are therefore cautioned to exercise great care and discretion in order to maintain this relationship. Any action by a practitioner which breaches this trust may raise the question of infamous conduct in a professional respect. The confidence

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60 Adopted on the 9th December 1986 replacing the 1975 Medical Ethics of the Malaysian Medical Council.

61 Act 50.

62 Medical Act, 1971, section 29(2)(b).

63 Ibid, section 30.

placed on doctors must also not be abused. A practitioner may not 'improperly disclose information which he obtained in confidence from or about a patient.'[64]

There is however, no definition of the term 'improper disclosure' of information obtained in confidence. Thus, a doctor who had disclosed such information must be prepared to justify that the disclosure was proper under the circumstances. Further guidance may be obtained from the Ethical Code issued by the Malaysian Medical Association (MMA).[65] Although the advice of the MMA has no disciplinary authority, it supplements that of the MMC. Section II of the said Code deals with professional confidence. It is stated in paragraph 2 of the Section:

> 2. Professional confidence implies that a doctor shall not disclose voluntarily, without the consent of the patient, preferably in writing, information which he has obtained in the course of his professional relationship with the patient.

Where difficulties arise, the overriding consideration must be the adoption of a line of conduct that will benefit the patient, or protect his interests.[66]

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64 Code of Professional Conduct, Malaysian Medical Council, at p 20.

65 Ethical Code, Malaysian Medical Association, 1990.

66 Ibid, at p 5.

The penalties provided for under section 30 of the Medical Act, 1971 include the striking off the name of such person from the Register or the suspension from the Register or a reprimand. These sanctions are of course, purely intraprofessional. Thus in the absence of statutory intervention, the common law position will still be relied on by the aggrieved patient.[67]

2. Statutory Notification

Confidentiality practised in Malaysia is not absolute. The requirement of mandatory notification overrides the individual's right to confidentiality to a certain extent. This is based on the rationale that public interest or public health precedes an individual's rights in such a situation. Here, it is undeniable that there is at the moment no vaccine or cure for the HIV infection. It is also a fact that the infection can be transmitted through certain means only. Under the circumstances, the authorities have legislated on the matter culminating in the Prevention and Control of Infections Diseases Act 1988 (Act 342). It was an amendment and consolidation of the law relating to the prevention and control of infectious diseases. HIV infection has been included in the

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67 Absolute medical confidentiality is found in France and Belgium, being protected in their Penal Code : art 378 and art 458 respectively.

list of infectious diseases.[68] The Act is an attempt to prevent and control HIV transmission and AIDS via the legislation.

Any existing duty or obligation on the part of the doctor to keep the matter confidential is thus overridden to the extent rendered necessary by the legal requirement of mandatory notification. Therefore, all suspected, confirmed cases and carriers of HIV are to be reported to the Health Officer in the district immediately by telephone, followed by the Health Form 1 currently in use.[69] This form however, is to be filled up in confidence. Further, epidemiological investigation of the reported cases will be immediately carried out tactfully by the Medical Officer of Health of the district.[70] Absolute confidentiality is not possible under the circumstances as partner notification or contact tracing can be carried out in some cases.

The HIV status of a person is confidential as far as the patient is concerned vis-a-vis his family members, friends and society. It does not cover the health authorities and the relevant health care workers. Thus, a doctor may inform his

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68 Part II, First Schedule of the Prevention and Control of Infections Diseases Act 1988 (Act 342).

69 See Appendix 11.

70 Ministry of Health's Plan of Action For the Prevention and Control of A.I.D.S., 1988, at p 14.

staff nurse that a particular patient is HIV positive. So too may the staff nurse inform the nurses who would be in direct contact with the patient. The policy of the government hospital is to limit the information on a need-to-know basis.

Would there be a breach of confidentiality on the part of the doctor if he decides to inform the patient's partner of his patient's seropositivity without the patient's consent? A search for guidance from the General Medical Council (GMC) and British Medical Association as well as their Malaysian counterparts do not provide any conclusive answer from any of them.[71]

Doctors seem to be left out in the cold to fend for themselves should they be sued later on by their patients for breach of confidentiality. The GMC had emphasised that the responsibility of such action by the doctor rests entirely on the doctor concerned. The doctor must be prepared to justify the said breach of confidentiality.

Although it can be argued on behalf of the doctor that besides owing the duty of confidentiality to his patient he also owes a duty to protect others, the delicate task of

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71 General Medical Council, HIV Infection and AIDS: The Ethical Considerations (1988); the British Medical Association is silent on the point in Philosophy and Practice of Medical Ethics (1988) and Rights and Responsibilities of Doctors (1988). Ethical Code of MMA (1990) and MMC's Code of Professional Conduct (1986).

balancing the two in the specific case of HIV-infected person has not been tested in the courts as yet. If the patient refuse to inform his partner of his seropositivity and the doctor based on the opinion that failure to disclose that fact would expose the partner to a possibly fatal risk of HIV infection, inform that person of his patient's seropositivity, one can only expect the court to accept the argument that such action was justifiable under the circumstances.

There is however, no duty, under the common law, to rescue a person with whom one has no relationship. Thus, strictly, there is no duty to warn in the absence of a special relationship between the parties.

This position can be contrasted with the common law duty in the United States and a statutory duty in some Canadian Provinces on the doctor to inform those at risk.[72] In the case of Tarasoff v Regents of the University of California[73], the patient had confessed to a therapist that he intended to harm a woman who had rejected his advances. The therapist kept the information confidential and did not warn the said woman. The

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72 L. Gostin and A. Ziegler, Review of AIDS-related Legislative and Regulatory Policy in the United States, (1987) 15 Law Med Health Care 5; DI. Casswell, Disclosure by a Physician of AIDS-related Patient Information: An Ethical and Legal Dilemma (1989) 68 Can Bar Rev 225.

73 529 P 2d 55 (Cal, 1974); 551 P 2 at 334 (Cal 1976).

woman was later killed by the patient. Her family successfully sued the therapist's employers based on the failure to warn her of the danger. Following the case, there were contrasting decisions on the point.[74]

The dilemma of the doctor on whether or not to inform his patient's partner is to a large extent alleviated by the fact that partner notification or contact tracing is provided for under the prevention and control of HIV infection/AIDS scheme implemented by the Ministry of Health. As all cases, carrier and contacts, of HIV infection/AIDS are to be investigated immediately by the Medical Officers of Health in the district where the report has been made, the question of confidentiality appears to be quietly pushed aside for the sake of ascertaining the source of infection and the mode of spread. As counselling is rendered, co-operation is more often than not forthcoming, making it irrelevant to question the propriety of informing the partner of the possibility of exposure to HIV infection as the patient would ultimately be persuaded to consent.

If the patient is adamant about not informing the partner, the officer would inform him of the power to investigate the case and the fact that the patient's act may

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74 Brady v Hopper 751 F 2d 329 (1984) and Petersen v State 671 P 2d 230 (Was 1983).

amount to an offence as stated under section 12(3) Prevention and Control of Infections Diseases Act 1988.[75] The investigation however is to be 'carefully and discretely' carried out.[76] A look at the format of the report sent to the Epidemiology Unit of the Ministry of Health after the epidemiological investigation is completed reflects the information to be obtained from the patient.[77] It includes the marital status, family history, medical history, risk factors and recent sexual contacts. The names and addresses of the contacts are also required although it need not be the full name or home address. This is to facilitate the tracing of partners concerned so that they can be counselled. Thus, confidentiality between the doctor and the patient is to that extent sacrificed and it is justified by the present surveillance and epidemiological investigation procedure carried out by the medical officers under the Minister of Health. This is based on the statutory notification required under section 10(2) of the Prevention and Control of Infectious Diseases Act 1988.[78] There is therefore no breach of confidentiality as it is justified by the statutory notification.

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75 Act 342.

76 Plan of Action for the Prevention and Control of AIDS, Ministry of Health, Malaysia, 1988, at p 11.

77 Appendix 11.

78 Act 342.

The MMA in its Ethical Code[79] states:

> Professional confidence implies that a doctor shall not disclose voluntarily, without the consent of the patient, preferably in writing, information which he has obtained in the course of his professional relationship with the patient ...
>
> Generally speaking, the State has no right to demand information from a doctor about his patient save when some notification is required by statute, as in the case of infectious disease.[80]

The Code of Professional Conduct by the MMC on the other hand provides a general guide on the matter:

> 2.2.1 **Abuse of Trust**
>
> Patients grant practitioners privileged access to their home and confidences and some patients are liable to become emotionally dependent upon the practitioner. Good medical practice depends upon the maintenance of trust between practitioners and patients and their families, and the understanding by both that proper professional relationships will be strictly observed. In this situation practitioners must exercise great care and discretion in order not to damage this crucial relationship. Any action by a practitioner which breaches this trust may raise the question of infamous conduct in a professional respect.

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79 1990.

80 Ibid at p 5.

2.2.2 Abuse of Confidence

> A practitioner may not improperly disclose information which he obtained in confidence from or about a patient.[81]

Where there is a requirement under the law for the doctor to notify the relevant authorities of his patient's seropositivity as is the case in Malaysia, the breach of confidentiality is legally justified. The contact tracing or partner notification is carried out by the relevant authorities and not the patient's doctor. There is therefore no dilemma faced by the said doctor in such a situation. His duty is to give notice of the existence of the infectious disease to the nearest Medical Officer of Health. It has been pointed out, however, that due to lack of manpower and resources contact tracing is not strictly to be carried out. Spouses however would normally be informed.[82]

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81 MMC Code of Professional Conduct, 1986, at p 20.

82 Interview with Dr Jit Singh on 9th July 1992.

3. Consent

Besides statutory requirement of notification imposed on doctors, the other situation where confidentiality of the patient's seropositivity may be set aside is where the patient himself consents to the release of such information. A doctor would be well advised to obtain the patient's written consent in such a situation. The MMA in its Ethical Code[83] states:

> Professional confidence implies that a doctor shall not disclose voluntarily, without the consent of the patient, preferably in writing, information which he has obtained in the course of his professional relationship with the patient.

The concept of consent is based on the premise of the ethical principle of respect for an individual's autonomy. Where the patient consents to the doctor informing a third party regarding his seropositivity, the confidentiality of the matter is to that extent negatived by the said consent. The MMA in its Ethical Code states further that:

> Medical information can be released to a third party ... only when written consent has been given by or on behalf of the patient. Third parties who frequently seek information from a doctor are employers who

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83 1990.

> request reports on the medical condition of absent or sick employees, insurance companies requiring particulars about the past history of proposers for life assurance or deceased policy holders, and solicitors engaged in threatened or actual legal proceedings. Where medical information is sought, the doctor should make it a rule to refuse to give any information in the absence of the written consent of the patient or the nearest competent relative.[84]

It is therefore clear that in such circumstances as mentioned above, written consent of the patient is to be obtained before such information can be released by the doctor. Unless there is a written consent from the patient, the seropositivity of the patient remains confidential.

There are however circumstances where a general or blanket consent is given by the patient. This include pre-employment medical check-up and the consent by the individual in the insurance proposal form. Where this is encountered, the rules of contract law applies. Strictly speaking, a general consent would cover confidential information such as that of the patient's seropositivity. It would therefore be wise for a person to read the small print

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84 Ibid, at page 6.

carefully before signing a form giving a general consent. There are other independent issues in relation to the doctor-patient relationship which will be dealt with in the following chapter on Partner Notification.

C. Insurance

Testing for HIV-antibody would have consequences in terms of insurance. Due to the unique features of the modes of HIV transmission and the fatality of AIDS, the insurance industry has responded in what is perceived as steps to protect itself from unjustifiable liability.[85] It is proposed that these steps be analysed with the background of existing facts pertaining to HIV infection and AIDS. The question of insurance coverage is looked at as it would be substantially responsible for the financial cost of the health care of the individual should the risk be covered. It would also be liable to pay the sum insured to the beneficiary in the event of the death of the insured in a life policy. The following discussion would be limited to life assurance.

A contract of life assurance is a contract to pay a certain sum of money upon the death of a person, in consideration of the the payment of certain annual premium

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85 The Star, 10 and 11 February 1992, 'Insurers seeks AIDS-safe guide' and 'Insurance firms gathering AIDS details.'

during his life. There is no need to prove actual loss or damage as a result of the death of the person insured as it is not a contract of indemnity.

Many insurance companies have responded to the HIV-infection and AIDS scare by incorporating certain questions in the proposal form in the hope that these would enable them to identify those in the high risk groups. Present underwriting guidelines have not fully taken into account the fact that HIV transmission are not limited to homosexuals. Insurance companies now consider single men above 35, hairdressers, fashion designers, airline stewards and entertainers to be in the high risk group. Those who have stayed for more than three months in the United States, Carribbean Islands, African Countries and Australia are viewed with suspicion.[86] People in these groups may be required to take blood tests. The requirement of HIV-test has also been made mandatory in certain application e.g. those that exceeded the threshold limit of $500,000 for an individual life.

The relevance of the questions asked and the accuracy and necessity of the HIV antibody test has been subjected to some debate especially by groups which feel that such practices are discriminatory and does not in any way alter the insurability of that person. Unfortunately, there is an

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86 Ibid.

absence of legislative prohibition of using the test for HIV antibody to assess insurability. As such, insurance companies in Malaysia are free to ask whatever questions they think would be relevant in their quest to assess the risk to be undertaken.

1. Duty of disclosure

The contract of insurance is unique in the sense that it is a contract of utmost good faith or a contract ubberimae fidei. Although the basic rules of a contract applies i.e. that there must exist an offer,[87] an acceptance[88] of that offer without any qualification, consideration[89] and an intention to create legal relations,[90] the early history of the development of insurance law has incorporated the element of utmost good faith into the contract. This was due to the fact that the proposer i.e. the individual seeking insurance coverage, is the person with personal knowledge of material information needed by the insurer to assess the risk and determine the premium to be

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87 Rules governing offer are found in sections 3, 4(1), 5(1) and 6 of Contracts Act 1950.

88 Rules governing acceptance are found in sections 3, 4(2), 5(2), 7 and 8 of Contracts Act 1950.

89 Defined in section 2(d) and governed by sections 24 and 26 of Contracts Act 1950.

90 Kwong Kum Sum (S) Pte Ltd v Lian Soon Siew & Ors [1984] 1 MLJ 150 at p 152. The Court of Appeal (Singapore) held that the general rule relating to the creation of a binding agreement is that 'for the parties to be bound they must have finished reaching an agreement, so that it is possible to infer an intention on the part of both of them to be bound immediately.

charged.[91] That being the case, a duty is imposed on the proposer to disclose such material facts. Thus, the burden is on the proposer to disclose such information. The well-established standard is that of the prudent insurer. Therefore, whatever information regarded as material or relevant by a prudent insurer ought to be disclosed by the proposer, eventhough no specific questions were asked nor the fact that the proposer did not know that it was a material information.[92]

The doctrine of utmost good faith is highlighted in section 16(4) of the Insurance Act 1963 by the requirement that a warning be prominently displayed in the proposal form stating that failure on the part of the proposer to fully and faithfully give the facts as he knows them or ought to know them could lead to a loss of benefits under the policy. A non-disclosure by the proposer would render the contract voidable at the option of the insurer.

However, the duty to disclose material fact is not confined to the proposer alone. It applies equally to the insurance company. In Re Bradley & Essex Suffolk Accident Indemnity Society[93] LJ Farwell reiterated:

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91 Carter v Boehm 97 ER 1162; Rozanes v Bowen [1928] 32 Lloyd's Rep. 98.

92 Joel v Law Union & Crown Insurance [1908] 2 KB 863 (CA).

93 (1912) 1 KB 415.

> Contracts of insurance are contracts in which ubberimae fides are required not only from the assured but also from the company assuring.

The duty on the part of the insurer was recently illustrated in the case of Banque Keyser Ullman v Scandia[94] where the plaintiff banks had agreed to lend money to B on the condition that appropriate credit insurance policies guaranteeing the loans were obtained. The broker, acting on behalf of the insurer wrongly told the plaintiffs that full insurance cover had been obtained when in fact it had not been. The insurers found out about the mistake but failed to inform the plaintiffs (insured banks) which made further loans. In due course, B absconded with the money. The insured banks claimed damages from the insurers'. It was held that by not disclosing the relevant facts, the insurers were in breach of the duty of utmost good faith they owed to the banks and that damages could be awarded due to that breach.

However, the Court of Appeal reversed the decision to award damages as a remedy. The decision of the trial judge that there was a duty of utmost good faith owed by the insurer to the insured was, however, affirmed.[95]

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94 [1987] 1 Lloyd's Rep 69; Banque Financiere v Westgate [1988] 2 Lloyd's Rep 513.

95 This decision was affirmed in 'The Good Luck' [1988] 1 Lloyd's Rep 514.

Notwithstanding the fact that the duty of utmost good faith applies to both the proposer and the insurer, it seems to place a more onerous burden on the proposer. The test to measure whether or not the facts are material or relevant is that of the 'prudent insurer'. In Lambert v Co-operative Insurance Society Ltd[96] the Court of Appeal applied the prudent insurer's test stating that the two prior convictions of Mr. Lambert were material and ought to have been disclosed. This basically means that an insured person has an especially heavy burden to discover what a prudent insurer would regard as material.

The 'prudent insurer' test has been well-established in law eventhough in recent years attempts have been made to change the position to one which would be more favourable to the public i.e. the 'reasonable insured' test. Counsels have forwarded arguments to the effect that it is unfair if not impossible to expect the proposer to read the mind of the insurer to find out what the insurer would consider to be relevant or material.

In the context of HIV infection and AIDS, the serological status of an individual is considered relevant by insurance companies. This is due to the fact that a person

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96 [1975] 2 Lloyd's Rep 485.

infected with HIV runs the risk of 'progressing' to AIDS, which at the moment is fatal. Accumulative statistics so far show increasing number of HIV infected persons acquiring AIDS in the various time period. There is no conclusive proof that a person infected with HIV will definitely get AIDS. Nevertheless insurance companies are concerned about increasing pay-outs to the insured and their beneficiaries.

Taking the law as it stands i.e. using the prudent insurer test in relation to material facts, there is no scope to argue that the serological status of an individual is in fact not relevant. So long as the prudent insurer considers it relevant, it is sufficient to warrant the fact as material. That being so, such a fact must be disclosed to the insurer, whether or not specific questions are asked in the proposal form. This is because the duty to disclose on the part of the insured is not absolved by answering questions on the proposal form alone. There is a residual duty to disclose[97] such material facts. The effect of the non-disclosure of a material fact by the proposer would render the contract of insurance voidable, at the option of the insurer.[98] The insurer may repudiate the contract upon notice of the said non-disclosure

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97 Teh Say Cheng v North British Mercantile Insurance Co. Ltd (1921) FMSLR 248.

98 Goh Chooi Leong v Public Life Assurance Co Ltd (1964) MLJ 5.

or within a reasonable time thereafter. Upon repudiation, the contract is void ab initio. The insurer need not honour any claim made under the said contract and is entitled to demand repayment of any sum so paid. The insured on the other hand is entitled, in the absence of fraud, to demand the repayment of such premiums as he may have paid.

2. Basis of contract clause

Where in the proposal form there is a basis of contract clause, every answer to the question becomes a warranty. If an inaccurate answer is given in the proposal form, the insurer will repudiate the contract i.e. avoid liability on the basis of a breach of warranty rather than non-disclosure. There is thus no need to prove materiality.

An interesting provision is section 15C(4) of the Insurance Act 1963. It excludes negligent failure to disclose after a life policy has been in force for more than two years. Any dispute by the insurer regarding such failure to disclose ought to be done within the first two years of its coming into effect. The insured who has been paying the premiums for more than two years is statutorily protected by section 15C(4). The basis of contract clause is to that extent negated by the said provision.

3. Rationale for the use of HIV Antibody Test in Underwriting

The various tests available in Malaysia identify those who are infected by HIV. They do not form automatic diagnosis of AIDS which is a clinical diagnosis. To date, no body, organisation or expert can say for sure that a person so infected would definitely develop AIDS. Data have shown that some develop AIDS or ARC within the first five years of being infected. Others remain healthy but develop it within 10 years. And there is a small group who have remained healthy up till today.

Considering the fact that HIV was identified only in 1982, one can only conclude that data so far do not paint the true picture of how HIV affects the immune system of various individuals. Scientists have acknowledged that factors like the diet, mental and physical well-being of the individual play a part in the development of AIDS.

Although it cannot be denied that there is a small percentage of false positive and false negative test results, it is a fact that a person infected with HIV runs a significantly higher risk of developing ARC or AIDS compared to one who is not infected at all. As such, although some may question the predictive value and actuarial significance of such tests vis-a-vis the insurance industry, the industry has resorted to such a measure in their effort to assess the risks they are undertaking.

The criticism forwarded by non-governmental groups and infected individuals is the fact that insurance companies discriminate against certain groups considered to be of high risks. The fact that an individual may remain asymptomatic and healthy for a number of years have also been pointed out. It is submitted that questions and assumptions pertaining to high risk groups are uncalled for and discriminatory. Whilst it is not to deny insurers of their right to assess the insurability of a particular individual, it would be more beneficial to all concerned if a more realistic and pragmatic approach is taken by insurers.

Questions asked in the proposal form and the test of HIV antibody ought to be on the basis of high risk behaviour and not high risk groups. The fact that HIV transmission is not limited to high risk groups has been well-established. In fact, high risk behaviour is the target of the WHO and the national programme on AIDS. The recent development of transmission within the heterosexuals have also exploded the myth that HIV transmission is limited to high risk groups.

Nevertheless, the substantially greater risk for insuring individuals who have been tested positive for HIV antibody is obvious. Insurance companies have taken the stand that such individuals are not insurable. An infected individual will therefore be rejected outright and would not be provided for under the insurance scheme.

In looking for the rationale behind the usage of HIV antibody tests prior to accepting a risk, a comparison can be drawn with other diseases. Life insurers operate on the basis of probabilities and not certainties. Many tests utilized in the underwriting process indicate the probability of occurence of one disease or another. The mortality and morbidity risk is then assessed. Presence of risk factors such as an elevated cholesterol level or being a cigarette smoker increases the health risk of an individual. So it is with HIV antibody test. Unfortunately, insurance companies have taken the easy way out by rejecting outright the application for life insurance by an infected person.

It is submitted that the current statistics available from the Ministry of Health and the WHO be utilised to form the basis of actuarial data to assess the increased risk of an infected person developing AIDS and thus dying early compared to an individual who is healthy. This data should be regularly updated to keep track of the development of knowledge in this field. Premium can be adjusted according to the increased risk. It would then be up to the individual whether or not to proceed with the application. Under the circumstances, there ought to be more awareness and social consciousness on the part of insurers. HIV infection and AIDS ought not to be treated differently from other diseases which are also fatal e.g. Hepatitis B.

In fact, in formulating the guidelines for HIV antibody testing procedures, the Life Insurance Association of Malaysia acknowledged the fact that it 'cannot be totally open about the basis for which it may call for HIV testing and what constitutes a high risk group.' The reason often cited by insurance companies to justify their actions is the solvency of the life insurance industry.

It is submitted however, precisely because of the solvency of the company and/or industry that actuarial science and adjustment of premiums have been the basis of the industry. It appears that the current total rejection of HIV infected person by the industry stems from the panic and paranoia associated with the infection and is not based on facts, and data as it should.

CHAPTER IV

PARTNER NOTIFICATION

A. Factors to be considered

Another area to be explored is partner notification.[1] World Health Organisation in its Global Programme on AIDS and Programme of STD has produced a Consensus Statement From Consultation on Partner Notification For Preventing HIV Transmission (hereinafter referred to as 'Consensus Statement').[2] Partner notification covers the sexual and injection equipment-sharing partners of persons with HIV infection. A partner has been defined as an individual who has had sex or shared injection equipment with the person with HIV or AIDS during the period of infectiousness. It is thus not limited to the legal spouse i.e. the husband or wife as the case may be.

Partner notification programme involves a spectrum of public health activities in which sexual and injection equipment-sharing partners of individuals with HIV infection

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1 Sometimes referred to as 'contact tracing'.

2 Geneva, 11-13 January 1989.

are notified, counselled about their exposure and offered services. This can be done either through patient referral or provider referral. In the former, the HIV-infected persons are encouraged to notify partner(s) of the possible exposure to HIV, without the direct involvement of health care providers. In the latter, the health care providers or other health care workers notify the said partner(s). Here the HIV-infected person identify his partner(s) to the health care provider who would then confidentially notify the partner(s) directly of the possible exposure to HIV infection without identifying the HIV-infected person.

The Consensus Statement cautioned that although partner notification programme should be considered, it must be within the context of comprehensive AIDS prevention and control programme. It is recognised that such a programme raises serious medical, logistical, social, legal and ethical issues. The potential benefits of helping prevent HIV transmission and reducing the morbidity and mortality of HIV infection and the potential risks of producing individual and social harm arising from discrimination and fear were noted. Society would lose a substantial bulk of its workforce as most of those infected are between 18-45 years old. In African countries, the number of orphans are increasing due to the death of their parents who suffer from AIDS. The cost and contribution of such a programme was also taken note of.

To help assist members in considering whether or not to implement a partner notification programme in addition to other HIV infection and AIDS prevention and control activities, objectives and principles were laid down. It was acknowledged that partner notification can contribute to the objectives of the Global AIDS Strategy by identifying individuals who have been exposed to HIV infection sexually or by sharing injection equipment, and informing them of the risks they have been exposed so that they can be offered counselling and other services.

Six principles are to be adhered to if partner notification is to be part of the AIDS prevention and control programme. Partner notification should:

(a) be in accordance with the Global AIDS Strategy and national AIDS programme goals;

(b) respect the human rights and dignity of the partners and the index person;[3]

(c) be a balanced part of a comprehensive AIDS prevention and control programme and be coordinated in the context of primary health care with other public health activities such as programmes on STD, maternal and child health, family planning and substance abuse prevention;

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3 HIV infected person.

(d) be voluntary[4] and not coercive, and index persons and their partners should have full access to available services independent of their willingness to cooperate with partner notification activities;

(e) be confidential, including written records, locating information for partners, and, in provider referral, the identity of the index person. Nevertheless, in an occasional provider referral situation such as where an index person has had only a single partner, the identity of the index persons may be able to be inferred;

(f) be undertaken only when appropriate support services are available to index persons and partners; the minimum requirements are counselling on the implications of having been exposed to infection, the availability of voluntary, confidential HIV testing with pre-test and post-test counselling and appropriate health and social services; the quality of these services should be assured and regularly monitored.

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4 In certain situations, when an index person refuses to notify or permit notification of a partner known to the health care provider, the provider will be required to make a decision consistent with medical ethics and relevant law.

Many factors need to be considered before partner notification is incorporated into the AIDS prevention and control programme. These are the epidemiology, existing resources, local environment and the existing AIDS prevention and control activities. The first deals with HIV seroprevalence, seroincidence and patterns of transmission and disease. Demographic factors and knowledge, attitude, beliefs and practices and the population groups are also relevant. Resources would take into account aspects like finance, personnel, facilities for diagnosis and management, developments in diagnosis, treatment and prevention and organization of health and social services. Local environment covers the relevant legislation, cultural considerations, political realities, social climate and perceived and actual threats to human rights. Finally, the existing activities include STD control programmes, maternal and child health, family planning and substance abuse control programmes.

In Malaysia, partner notification is not fully and rigorously implemented due to several reasons. These are basically related to available resources. The Ministry of Health do not have sufficient finance and trained counsellors to implement the programme effectively.[5] Partner notification

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5 Interview with Dr Jit Singh of the Ministry of Health on 9th July 1992 and Dr. Zainol of the Dewan Bandaraya Kuala Lumpur on 19.10.92.

is carried out as and when it is possible and deemed necessary. Thus it is necessary to explore the possible legal issues that may arise.

Is there a duty on the part of the HIV-infected person to inform his partner? What if the partner is not his or her legal spouse i.e. wife or husband? Must the doctor keep the seropositivity of the patient confidential vis-a-vis the partners? What if the partner(s) is also the doctor's patient? How far would partner notification affect the confidentiality?

In the following discussion, references will be made to the Consensus Statement. It is noted that the Consensus Statement has no legal binding force on the participants to the said Consultation on Partner Notification For Preventing HIV Transmission. Nevertheless, it serves as a useful guide in dealing with legal issues that may arise as it looked at the various possible difficulties that may be encountered if a partner notification programme is to be enforced.

There are several factors which are essential to the following discussion. Firstly, the known modes of HIV transmission. Secondly, the availability of tests for HIV-antibody. Thirdly, the risks of the infection developing into AIDS and finally, the fact that there is no cure or

vaccine for HIV infection and AIDS. Taking all these factors into consideration, it is of utmost importance to determine whether the person who is HIV-infected owes a legal duty to inform his partner(s) of his seropositivity. This issue arises mainly because of the risks of transmission to the partner(s). There are several variables in this situation. The contact, be it sexual or injection-equipment sharing, may be in the past or continous and existing. There is also the fact that it is difficult to determine the exact period of infectiousness. The confidentiality of the matter would also be of relevance to the discussion.

B. Notification by HIV Infected Person to Partner(s)

Ethically, the HIV-infected person should inform his partner of his seropositivity. It is a moral obligation on his part to ensure that no harm i.e. HIV infection and the subsequent development of ARC or AIDS, comes to the partner. This is especially so since preventive measures can be taken. In this chapter, discussion will focus on the implication of partner notification on the various branches of law. These include the tort of negligence, family law and criminal law.

1. Negligence

(a) Duty of Care

Under the tort of negligence, a person owes a duty of care towards his 'neighbour'. A person must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure the neighbour. This was stated in the case of Donoghue v Stevenson.[6] The term 'neighbour' has been defined by Lord Atkin as 'persons who are so closely and directly affected by my act [or omission] that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.'[7] Although the case is concerned with the duty owed by manufacturers to the ultimate consumers of their products, developments in the law indicate that it is possible for this duty of care to be imposed in other circumstances.

This was suggested by Lord Reid in Home Office v Dorset Yacht Co Ltd[8] where the learned judge said:

> ... the well-known passage in Lord Atkin's speech [in Donoghue v Stevenson] should I think be regarded as a statement of principle ... I think that the time has come when we can and should say that it ought to apply unless there is some justification or valid explanation for its exclusion.

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6 [1932] AC 562, at p 580 per Lord Atkin.

7 Ibid.

8 [1970] AC 1004, at p 1027.

The House of Lords in Anns v Merton London Borough Council[9] acknowledged that in order to establish that a duty of care arises in a particular situation, it is not necessary to bring the facts of that situation within those of previous situations in which a duty of care has been held to exist. In deliberating on the matter, Lord Wilberforce stated that the question has to be approached in two stages.[10]

First, one need to ask whether as between the alleged wrongdoer and the person who has suffered damage there is a sufficient relationship of 'proximity or neighbourhood' such that, in the reasonable contemplation of the former, carelessness on his part may be likely to cause damage to the latter. In such a case, a prima facie duty of care arises. Secondly, if there is such a duty, to consider whether there are considerations which ought to negate, reduce or limit the scope of the duty or the class of persons to whom it is owed or the resultant damage. The expansive reliance on the above has resulted in cases such as Junior Books Ltd v Veitchi Co Ltd[11] where economic loss was included in the scope, conflicting with well-established principles of the type of damage that can be claimed under the branch of negligence.

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9 [1978] AC 728.

10 Ibid, at p 751-752.

11 [1983] 1 AC 520.

The test can, in short, be narrowed down to one of reasonable foreseeability of the injury. There need not be actual physical proximity for the duty of care to arise. It is sufficient if the victim be in the class of persons with the foreseeable injury. Thus, there is no need for the foreseeable victim to be identifiable by that person.

It is submitted that a person who is seropositive owes a duty of care to the group of persons whom it can be reasonably foreseen would be injured by his acts or omissions which result in the transmission of HIV. In this case it would encompass his partner(s).

To succeed in a claim for negligence, the three elements have to be proven. Firstly, that there exist a duty of care. Secondly, that there has been a breach of that duty. Finally, there must be injury as a result of that breach.

(b) Breach of duty of care

After establishing the existence of the duty of care owed by a person who is HIV positive to his partner, it is to be shown that there has been a breach of that duty. If the HIV-infected person takes all the necessary precautions recommended to prevent the transmission of HIV, is there any further need to inform his partner of his seropositivity? In other words, is there any duty to inform his partner of his seropositivity? It

is submitted that duty of care should be distinguished from duty to inform. If the HIV-infected person practices the necessary precautions insofar as prevention of HIV transmission is concerned such as the use of condoms or the proper disinfection of the injection needles used, it can be argued that he has fulfilled his duty of care towards his partner. Thus, there is no need for him to disclose the fact that he is HIV positive to his partner. This argument presumes that the HIV infected person is responsible enough to take all the necessary precautions. It also assumes that he knows of such precautions.

On the other hand, it can be argued that the duty to inform is part of the duty of care owed to the partner(s). This is due to the seriousness of the risks of transmission and its corresponding risks of developing AIDS. The ultimate injury would be the threat to that person's life as there is no cure for the infection presently. AIDS would ultimately result in death as the body's immune system breaks down completely. Incorporating duty to inform as part of duty of care would impose a duty on the part of the HIV infected person to inform those who can be reasonably foreseen would be likely to be injured (this would include his partner(s)) of his seropositivity. That being the case, failure to inform the partner may constitute a breach of the duty of care.

This position may attract objections as it may encourage law suits based on such a premise. There may be fear that adopting this position may open the floodgate to litigation. The traditional tort dilemma would be faced. Should the duty of care be expanded or should the floodgate argument be allowed to reign? It is to be recognised that the Malaysian society is not as litigious as the Americans. In such a situation as above, where the life of a person may be threatened, the writer would propose that a wider scope of duty of care be allowed to enable action be taken by the affected person. It would at least be an avenue for the affected person to seek remedy. It is untrue to equate the expanding of the duty of care with the increase in the number of possible litigation. Duty of care is only one of the three elements to be proven in an action based on negligence. As will be discussed later, the other two elements would to a large extent limit the number of actual cases that would be brought to court.

The test applied in determining whether there has been a breach of duty is that of a reasonable man. It is as stated by Alderson B in Blyth v Birmingham Waterworks Co:[12]

> Negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do.

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12 (1856) 11 Ex 781, at p 784.

Whether or not failure to inform his partner amounts to a breach of duty of care depends on the test of the hypothetical reasonable man. In using the reasonable man test, the court would be dealing with what that hypothetical reasonable man would do under the circumstances. Should this test be applied? The question is posed because in the case of HIV transmission, can the reasonable man be put in the situation the HIV infected person is in? The 'situation' here is not a scenario which is usually the case but the seropositivity of that person which entails with it various emotional and social distress. Can the 'reasonable man' appreciate the implications of being HIV antibody positive?

These questions are raised as it is felt that the reasonable man test may not be a good test because of the reality of circumstances.

If we adopt the more subjective approach, i.e. that of a reasonable HIV infected person, it imports with it various problems. This is because there are so many variables in that group of the HIV infected persons. This includes the modes of transmission, age, background, etc which would influence the behaviour and reaction of that particular individual. Comparison can perhaps be drawn to the reasonable man standard in the criminal law which have been modified in certain

instances for example in cases of provocation.[13] Nevertheless, it remains to be seen how the court would expand or modify the reasonable man test in cases of HIV transmission.

Using the traditional reasonable man approach, the application of this test in a particular case depends on the magnitude of the risk, importance of the object to be attained and the practicability of precautions. Therefore, a balance must be struck between the magnitude of the risk and the burden to the defendant in doing (or not doing) what it is alleged he should (or should not) have done. The degree of care is to commensurate with the risk.[14]

The court need to consider in the current situation of failure to inform the partner of his seropositivity whether the risk of HIV transmission was sufficiently great to require of the defendant more than what he has actually done, for example taking precautions on his own without informing his partner of his seropositivity. The likelihood that the injury will be incurred[15] and the seriousness of the injury risked[16] are two

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13 Further discussion would not be attempted here as it goes beyond the scope of this partial thesis. The writer accedes however, that this crucial point of law need to be tackled in the current climate of widespread infection in the world.

14 Read v J Lyons & Co Ltd [1974] AC 156, per Lord Macmillan at p 173; Lloyds Bank Ltd v Railway Executive [1952] 1 All ER 1248, per Denning LJ at p 1253.

15 Bolton v Stone [1951] AC 850; Hilder v Associated Portland Cement Manufacturers Ltd [1961] 1 WLR 1434.

16 Paris v Stepney Borough Council [1951] AC 367.

factors in determining the magnitude of the risk. Unfortunately in this case, even though it can be agreed upon that the risk of the injury is serious as there is no cure or vaccine to HIV infection which may ultimately develop into AIDS, the likelihood of injury is rather difficult to ascertain as it involves certain variable factors. These include the modes of HIV transmission and the precautions taken by the person. The precautions are not 100 per cent proven to be effective. They merely minimises the risks of transmission.

As far as the importance of the object to be attained is concerned, it is submitted that the life at stake of the partner is of sufficient importance in the balancing of the risk against the consequences of not taking it. Unless some valid reasons can be forwarded for not informing the partner, it can be argued that a reasonable man, in the circumstances, would inform the partner of his seropositivity so that the partner can also take the necessary precautions and be given the choice of whether or not to continue the association with the HIV-infected person.

The risk of injury arising out of the act of not informing the partner is quite substantial that it would justify the requirement of informing the partner of his seropositivity. The embarassment, fear and desire to keep the matter confidential is not sufficient, it is submitted, to justify the exclusion of the precaution of informing the partner of his seropositivity.

(c) Injury/Damage

The next factor to be considered is whether the injury or damage is the result of the breach of that duty of care. The causal link must be proven and it must not be too remote. The generally accepted test used by the courts to determine the causal link is the 'but-for' test. Basically, if the result would not have happened but for a certain incident, then that incident is a cause. The test is neatly illustrated in Barnett v Chelsea and Kensington Hospital Management Committee[17] where three patients went to the hospital early in the morning and complained of vomitting after drinking tea. The doctor was consulted by the nurse on duty by telephone. The men were advised to go home and consult their own doctors later in the morning. Some time later on the same day, one of the men, plaintiff's husband, died of arsenic poisoning. Although there was a breach of his duty of care on the part of the doctor in failing to examine the patient, it was found that the breach was not a cause of the death. Plaintiff's claim failed because even if the deceased had been examined and treated with proper care, the probability was that it would have been impossible to save his life. Thus, the court is only concerned with what would have happened if the breach of duty had been removed from the set of events and replaced by rightful conduct on his part.

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17 [1969] 1 QB 428.

If the result would have been the same, then the breach is not a cause. The plaintiff has to prove on the balance of probabilities that but for the defendant's breach of duty, the injury would not have been suffered.

The difficulty in proving causation can be further illustrated by looking at decided cases. In Kay v Ayrshire and Arran Health Board[18], a child suffering from meningitis was given an overdose of penicilin during treatment. Remedial treatment counteracted the immediate effect of this. However, after recovery from meningitis, the child was found to be suffering from deafness. Expert evidence at the trial stated that an overdose of penicillin had never been known to cause deafness but that it was a common sequel of meningitis. The trial judge ruled in favour of the plaintiff. It was reversed on appeal and this was confirmed by the House of Lords. The House of Lords held that where there were two competing causes of damage, i.e. the overdose and the meningitis in this case, the law could not presume in the plaintiff's favour unless it was first proved that that particular tortious act was capable of causing such damage. Since this was not established, the deafness had to be considered as resulting solely from the meningitis.

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18 [1987] 2 All ER 417.

Similarly in Hotson v East Berkshire Area Health Authority[19], failure to prove causation was fatal to the claim. The case concerned a child who had a fall and injured the hip. The injury was not correctly diagnosed at the hospital and the child was sent home. Subsequently he returned to the hospital due to the pain. He was given emergency treatment when the nature and extent of his injury became apparent. He was however, left with a severe condition causing deformity of the hip joint. His claim for negligence was based on the delay in diagnosis. Breach of duty was admitted by the hospital but an argument was put forward that the delay had not adversely affected the plaintiff's long-term condition. At the trial it was found that even if a correct diagnosis had been made the first time, there was still a 75 percent risk of the disability developing. The trial judge gave the plaintiff 25 percent of the full value of the damages awardable and this was affirmed by the Court of Appeal. The House of Lords however, reversed the decision holding that since it was held by the trial judge that on the balance of probabilities, even correct diagnosis and treatment would not have prevented the disability from occuring, the plaintiff had failed on the issue of causation.

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19 [1987] 2 All ER 909.

The combination of causes is well illustrated in Wilsher v Essex Area Health Authority[20] where a plaintiff's injury was attributable to a number of possible causes, one of which was the defendant's breach of duty. The combination of causes did not give rise to the presumption that the defendant's breach of duty had caused the injury. The burden would remain on the plaintiff to prove the causation link. In this case, the damage to the retina resulting in near blindness could have been caused by five other conditions common in premature babies which afflicted the plaintiff. The insertion of a catheter into the vein rather than an artery resulting in excess oxygen is another possible cause for the injury suffered. The House of Lords held that the plaintiff had not discharged the burden of proving that the injury was caused by the defendant's breach of duty.

This third element of causal link would pose some difficulty in a situation where a partner has been infected by HIV. This is because of difficulty in determining the period of infectiousness of the HIV-infected person. The problem would be further complicated if the partner had other exposures to HIV infection during the relevant time-frame. There is no

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20 [1988] 1 All ER 871.

definite period of incubation.[21] It has also remained uncertain as to whether all persons with HIV infection will develop AIDS. Some people with HIV infection remain healthy for several years before developing any symptoms of AIDS Related Complex or AIDS. Nevertheless, statistics increasingly show a higher percentage of HIV infection developing into AIDS. If AIDS is the injury in question, then the plaintiff need to prove that it was the result of his partner's (who is HIV-infected) breach of duty of care to him. This may include the non-disclosure of his seropositivity, which if known to the plaintiff would have seen him either taking the necessary precautions to prevent HIV infection or severing the relationship altogether.

Can HIV infection per se be classified as injury or damage to the person concerned? Although HIV infection per se would not injure a person initially, the fact that it attacks the body's immune system and leaves it wide open to various infections and cancers would, it is submitted, suffice for it to constitute injury. It is the consequence of HIV infection, which at present is lifelong, which would undoubtedly cause some form of physical injury to the person.

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21 Report of an International Consultation on AIDS and Human Rights, UN, New York, 1991, at p 30.

The final requirement of causal link would exclude those who have not been infected yet as there is no injury as such. A person cannot take an action in the tort of negligence to enforce an obligation or duty on the part of the HIV-infected person to inform one of his seropositivity. The purpose of an action in negligence is basically to compensate the victim for the injury suffered. Thus if no injury has been suffered as yet i.e. HIV infection not detected yet, an action in negligence would fail. It is questionable if an action in negligence would be of any help except perhaps on the financial aspect. Even this would depend on whether the defendant i.e. the HIV-infected person, can afford to compensate.

In the peculiar context of HIV transmission and AIDS, several factors need to be highlighted. Firstly, the uncertainty of infection in some cases due to the possibility of the 'window period'. Secondly, even if HIV infection is affirmed, there is no way of assessing the extent of the actual injury that would be suffered in the near future. Thirdly, there is the uncertainty of whether the infection would ultimately lead to AIDS in that particular case. The possibility of the infection lying dormant and undetected for a number of years is well documented. Taking all these factors into consideration, is there no scope of expanding tortious liability to cover potential injury? Can the fear of getting infected (with HIV from the HIV infected person) per se be

sufficient to constitute 'injury'? Can a person who had been exposed to the risks of being infected for example via blood transfusion or sexual intercourse, and suffered fear and mental anguish claim that these constitute injury? If so, how is the court going to assess such injury in terms of compensation? It is submitted that elements such as fear and mental anguish have been traditionally included in the calculation of compensation in other cases such as that of accident. Therefore, these elements ought not be cited as being impossible to be assessed by the courts.

If the traditional tortious liability is not adapted to widen its scope, those who have been exposed to the infection would find it extremely difficult, if not impossible, to resort to the tort of negligence for remedy. If however, the expansion of the scope of injury is favoured so as to encompass potential injury, another aspect of law may need to be altered. It is the limitation period imposed by law as will be discussed below.

(d) Limitation

Another crucial factor is that of time. It may be a number of years before the HIV infection is detected or AIDS diagnosed. One has to consider this point as the action in tort may be

barred by the time limitation which is six years from the date on which the cause of action accrued. This is as stated in section 6(1)(a) of the Limitation Act 1953[22]:

> Save the hereinafter provided the following actions shall not be brought after the expiration of six years from the date on which the cause of action accrued, that is to say -
>
> (a) actions founded on a contract or on tort.

A cause of action has been described in the case of Lim Kean v Choo Koon[23] by Yong J:

> A cause of action normally accrues when there is in existence a person who can sue and another who can be sued, and when all the facts have happened which are material to be proved to entitle the plaintiff to succeed. ... the period of limitation does not begin to run until there is a complete cause of action, and a cause of action is not complete when all the facts have not happened which are material to be proved to entitle the plaintiff to succeed.[24]

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22 Act 254.

23 [1970] 1 MLJ 158.

24 Ibid, at p 159.

Thus in an action based on negligence, the plaintiff must first determine that the defendant is still alive or if he has passed away, that there is an estate left behind. The plaintiff then need to determine that all the necessary elements of the tort of negligence are present and can be proven i.e. there must exist a duty of care owed by the defendant to the plaintiff, there was a breach of that duty and finally, as a consequence of that breach there was damage or injury caused to the plaintiff. The difficulty of proving each and every element has been discussed earlier.

The limitation period of six years applies to an action based on the tort of negligence. The six years is counted from the date on which the cause of action accrued.[25] In tort, the cause of action accrue at the date when damage occurs. In the case of Pirelli General Cable Works Ltd v Oscar Faber & Partners (a firm)[26] where an action was taken against the consultant engineers in respect of negligent design of the chimney, the House of Lords held that the cause of action accrued at the date when physical damage i.e. cracks occurred to the building as a result of the defect. This is regardless whether that damage could have been discovered with reasonable diligence at that date by the plaintiff.

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25 Limitation Act 1953, section 6(1).

26 [1983] 1 All ER 65.

In a case where HIV infection has occurred, the question would be whether the infection per se amounts to damage. If not, would one need to wait for actual physical injury to the health of the person concerned? Need there be a diagnosis of ARC or AIDS to conclusively state that there is damage? Time would run from the date damage occurs, regardless whether the person had discovered the damage. It therefore depends on what constitutes damage in this instant. Practical aspects would put further obstacles for the plaintiff in such a case. It may be years before HIV infection is discovered or AIDS diagnosed. There is also difficulty in determining the exact time of infection. There is the uncertainty of when the cause of action actually accrue. These difficulties are further compounded if there are multiple partners involved. This would hamper the court to rule definitively when the limitation period begin to run. If such is the case, the court may have to decide what test to adopt - would it be when HIV infection is detected or AIDS diagnosed? The impossibility of finding out scientifically when exactly the HIV infection occurred or when the infection would progress to the stage where it affects the health of a person via the various infections and cancers would impede any attempts of pinpointing conclusively when damage or injury occurs. By the time it is known, even assuming that it can be proven that it was a result of the breach of duty owed by the defendant to the plaintiff, the plaintiff might not be in time to sue, assuming it can be

determined when the cause of action accrue. In other words, the plaintiff may be barred by time limitation as stated in section 6(1) of the Limitation Act 1953.

That being the case, it is perhaps time for the courts to acknowledge the fact that in some circumstances such as that of HIV infection, AIDS and radiation, it is just not possible to fit the case within the narrow confines of the limitation period imposed by law. The reality is too full of uncertainties. This however, does not mean that no injury is caused. Indeed, in cases such as those mentioned above, the consequences amounting to the injury may be far worse than the traditional tort cases. Is it fair to deny such potential plaintiffs the remedy in law when there is no other way of obtaining redress that would benefit them?[27]

The present limitation period as stated in section 6(1)(a) of the Limitation Act 1953[28] referred to above is insufficient if HIV infection and AIDS cases are to be given a chance to be even brought before the court. It is high time that such cases be considered as there would be more and more HIV infection in Malaysia and throughout the world. Presently,

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27 Criminal law would seek to 'punish' the offender and offers no remedy to the victim except the solace obtained from the fact that the offender has been apprehended and charged.

28 Act 254.

it still cannot be conclusively stated, how long it would take for AIDS to develop. There are too many variables such as the health of the person at the time infected, diet and also the mental attitude of that person. Nevertheless, statistics can be used as a guide to determine the average time it takes for HIV infection to progress to AIDS in the various groups. Based on statistics provided by the WHO and the Ministry of Health, an estimate of the time period can be arrived at. Whatever the time period may be, it is quite certain that the six years limitation as provided for at present is too short. Perhaps a cut-off point of twelve years is more realistic. It would also be left to the legislature to consider whether to amend the time period outright or to make exceptions to the stated six years in cases such as HIV infection, AIDS, radiation or even pollution which takes years before any injury can be positively identified.

(e) Volenti non fit injuria

In addition to the above, there could be an argument on the part of the defendant i.e. the HIV-infected person that the plaintiff i.e. his partner had voluntarily assumed the risk of being injured. Volenti non fit injuria is a voluntary agreement by the plaintiff to absolve the defendant from the legal consequences of an unreasonable risk of harm created by the defendant, where the plaintiff has full knowledge of both the nature and extent of the risk. (Volenti where it is

successfully pleaded is a complete defence). In other words, the plaintiff had consented to being exposed to the risk of being infected by HIV. This defence is based on a fundamental principle of the law that one who consents to being injured cannot make the one who causes his injury liable.[29] This defence however, can only be pleaded if there has been an agreement between the parties, be it express or implied, prior to the alleged tortious act to that effect. Lord Denning M.R. in Nettleship v Weston[30] said:

> Nothing will suffice short of an agreement to waive any claim for negligence. The plaintiff must agree, expressly or impliedly, to waive any claim for any injury that may befall him due to the lack of reasonable care by the defendant.[31]

Most of the members of the House of Lords in ICI Ltd v Shatwell[32] had also indicated that an agreement is the basis of the defence.

Although there is uncertainty as to what would constitute an implied agreement to that effect, the phrase 'voluntarily assumed the risk' connotes knowledge on the part of the plaintiff of the risk concerned.

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29 Consent of Parties and Volentas Legis [1966] CLJ 75; Volenti Non Fit Injuria [1985] CLJ 87.

30 [1971] 2 QB 691.

31 Ibid, at p 701.

32 [1965] AC 656.

The agreement of the plaintiff must be 'voluntary' meaning he must have a genuine choice. This is stated by Scott LJ in Bowater v Rowley Regis Corporation[33]:

> A man cannot be said to be truly 'willing' unless he is in a position to choose freely, and freedom of choice predicates, not only full knowledge of the circumstances on which the exercise of choice is conditioned, so that he may be able to choose wisely, but the absence from his mind of any feeling of constraint so that nothing shall interfere with the freedom of his will.

The knowledge that the plaintiff must have is not just the existence of the risk. It must be full knowledge of both its nature and extent.[34] As such, constructive knowledge is insufficient. Where the plaintiff did not know but ought reasonably to have known of the risk, he is not volens.[35]

It is submitted that in cases of HIV transmission which occurs mainly without the knowledge of the party being infected, this defence cannot be pleaded at all. It is only when all the elements discussed above have been fulfilled that the defendant can bring in volenti as a defence. Only in cases where the person exposed to the risk has full knowledge of the

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33 [1944] KB 476, at p 479.

34 Wooldrige v Sumner [1963] 2 QB 43, at p 69.

35 Dixon v King [1975] 2 NZLR 357.

defendant's seropositivity and knows of the nature and extent of the risk of HIV transmission can it be said that the person concerned has full knowledge. Further, with that knowledge, that person must have chosen to undertake such risks despite the said knowledge. Only if there is knowledge coupled with a true or real consent will the plaintiff be volens and the defendant's liability excluded.

It is however, rare for this defence to succeed today as there is a preference to rely on contributory negligence instead. The apportionment of responsibility is regarded as fairer than denying redress where the defendant was in breach of duty.[36]

(f) Conclusion

Based on the discussion above with regards to the essential elements of the law of negligence, it has been shown that there is a possibility of 'imposing' a duty to inform the partner as part of the duty of care owed to one's neighbour. There would be difficulty in ascertaining the nature of the breach of that duty unless one takes the position that failure to inform the partner of his seropositivity amounts to a breach of that duty. In support of this, the argument that the other party

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36 Nettleship v Weston [1971] 2 QB 691, at p 701.

i.e. the partner has the right to know and the right to decide for himself whether or not to assume the risk of infection by continuing his association with the HIV-infected person can be forwarded. The final element of injury or damage that resulted from that breach can only be proven if there is HIV infection or AIDS.

Looking at the aims and objectives of the Global Programme on AIDS, the national programme on the Prevention and Control of AIDS and the principles adopted in the Consensus Statement[37], it can be concluded that taking an action in negligence is not an effective remedy to the individual concerned. Nor is it a solution in the context of the national AIDS programme. One of the principles adopted in the said Consensus Statement is that partner notification should be voluntary and confidential. Suing the person for negligence is no solution at all.

2. Family Law

A legal spouse is the husband or wife of the HIV infected person. It is essential to explore the rights and obligations between the husband and wife in order to be able to determine whether there is a duty to disclose information regarding one's seropositivity to the spouse.

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37 Consensus Statement From Consultation on Partner Notification For Preventing HIV Transmission, Geneva, 11-13 January 1989.

The basis of a legal spouse is the institution of marriage. The institution of marriage has eluded an exact definition for the simple reason that it varies according to the culture, place and time-frame in question. It would nevertheless be useful to look at some of the definitions.

The case of Hyde v Hyde[38] has described marriage under common law as the voluntary union for life of one man and one woman, to the exclusion of all others.

Under the Law Reform (Marriage and Divorce) Act 1976[39], there are certain criteria that must be adhered to in order to constitute a valid marriage. The marriage must be of a monogamous nature.[40] There are restrictions as to the minimum age for marriage[41] and a list of prohibited relationships.[42] The requirement of consent is also dealt with.[43]

Is there any duty on the part of the HIV infected person to notify or inform his spouse of his seropositivity?

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38 (1866) LR 1 P & D 130.

39 Act 164.

40 Ibid, section 5.

41 Ibid, section 10.

42 Ibid, section 11.

43 Ibid, sections 12, 37, 70(c), (d).

Can this duty be enforced? To answer these questions, one has to look at it in the context of the mutual expectations that arise in such a relationship.

As it is, there is no legal obligation imposed on an individual to inform the spouse of his seroposivitity. There are however, provisions which may be referred to to clarify this position. The non-disclosure of such an important fact which not only would affect the spouse but also future plans of having children may constitute a ground for divorce. Under the Law Reform (Marriage and Divorce) Act 1976,[44] the sole ground for divorce is the irretrievable breakdown of marriage. This is stated in section 53 of the said Act. The court would inquire into the facts and circumstances alleged as causing or leading to the breakdown. One of the facts to be taken into account is that the respondent has behaved in such a way that the petitioner cannot reasonably be expected to live with the respondent.[45]

A simple assertion that the petitioner cannot reasonably be expected to live with the spouse (respondent) would not suffice as the court need to consider the characteristics and behaviour of both the parties. In the case

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44 Act 164.

45 Ibid, section 54(1)(b).

of Pheasant v Pheasant[46] where the husband alleged that the marriage had irretrievably broken down in that he found it impossible to live with the wife any longer, the court looked at the reasonableness of the characters and behaviours of each of them. Here, it was found that the husband's complaint was that the wife had not been able to give him the spontaneous, demonstrative affection he wanted and had no other serious criticism of the wife's behaviour. The wife on the other hand had no complaints and would welcome her husband's return. The court found that there was no breach of behaviour on the part of the wife and that therefore the husband was not entitled to a decree nisi.

The objective test of reasonableness where the court considers the behaviours of both parties was again applied in Richards v Richards[47] where the court held that it is required to make a value judgment about the behaviour of the respondent and its effect on the petitioner and to take into account, inter alia, the temperament of the parties and the mental illness of the respondent. The wife's petition for a divorce was dismissed as the court held that she had failed to establish that the husband had behaved in such a way that she could not reasonably be expected to live with him.

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46 [1972] 1 All ER 587.

47 [1972] 3 All ER 695.

An interesting case is that of Thurlow v Thurlow[48]. At the time of the marriage in 1965, the husband knew that the wife was an epileptic but believed that her condition would improve. By 1970, the wife's condition deteriorated due to severe neurological disorder. The husband had to do housework, nurse his wife and prepare her meals in addition to a full-time job. The wife was bad-tempered, threw objects at his mother and burnt household items. She also had bouts of silence. In 1971, she was hospitalised and was allowed home in 1972. After three weeks, the husband could not cope anymore and took his wife back to the hospital. His health and performance at work were affected. The wife required inpatient institutional care for the rest of her life. The husband then petitioned for divorce on the ground that he could not reasonably be expected to live with his wife. The court granted the decree nisi.

More importantly, the court held in this case that behaviour included negative conduct and involuntary conduct due to mental or physical illness or injury. The wife's conduct was held to constitute behaviour.

It may therefore be argued that by not disclosing the seropositivity to the spouse and by his other conduct of not revealing the true nature of the situation, the respondent had behaved in such a way that the spouse cannot reasonably be

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48 [1975] 2 All ER 979.

expected to live with the respondent. This is due to the fact that there is a risk of transmitting HIV to the spouse and the foetus (if the spouse subsequently gets pregnant) and the fact that in the current there is no proven treatment of HIV infection which in its full-blown state of AIDS, is fatal. Thus, the endangering of the life of the spouse threatens the very basis of the marriage - the mutual trust and understanding. Can a spouse be reasonably expected to live with the respondent in such of situation? It is submitted that if deceit occurs via non-disclosure, then the spouse may very well be entitled to say and feel that he/she cannot reasonably be expected to live with the respondent.

The proper test to be used by the court in considering a petition for divorce under section 54(1)(b) of the Law Reform (Marriage and Divorce) Act 1976[49] was reiterated by the High Court in Joseph Jeganathan v Rosaline Joseph[50]. The test is whether a right thinking man in all the circumstances would conclude that the respondent had behaved in such a way that the petitioning spouse could not reasonably be expected to live with the respondent. The court would take into account all the circumstances including the characters and personalities of the parties, their conduct and the interests of any child of the marriage.[51]

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49 Act 164.

50 [1989] 3 MLJ 106.

51 Ibid, section 54(2).

Although there is no specific legal provision requiring disclosure by an individual to the spouse, there is a very strong moral basis for disclosure. This is undeniable especially where the basis of the marital relationship is so basic as to encompass trust and understanding. The possibility of obtaining a divorce as stated above further strengthen the argument for the disclosure of the person's seropositivity to the spouse. The Law Reform (Marriage and Divorce) Act 1976 however, applies only to non-Muslims.[52]

For a Muslim, the case might even be stronger. The Muslims are governed by the respective State Enactments. The Islamic Family Law (Federal Territory) Act 1984[53] is referred to in the following discussion. A Muslim's marriage can be dissolved through several means i.e. talaq[54], tebus talaq[55], ta'liq[56] and fasakh[57]. The relevant mode would be "cerai fasakh" whereby a woman married in accordance with Hukum Syara'is entitled to obtain an order for dissolution of

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52 Ibid, section 3(3).

53 Act 303.

54 Ibid, section 47.

55 Ibid, section 49.

56 Ibid, section 50.

57 Ibid, section 52.

marriage or fasakh on any of the stated grounds[58] and any other ground recognized as valid for fasakh under Hukum Syara'.[59]

Paragraph (f) of section 52, Act 303 included venereal disease in a communicable form as one of the grounds for fasakh. The question of course is whether HIV infection and AIDS can be classified as venereal disease in a communciable form. Although it may be challenged, it ought to be remembered that one of the modes of transmission is via unprotected sexual intercourse. And since marital obligations in a marriage includes sexual relations, the fact that HIV can be so transmitted and that there is at present no cure compared to some other venereal diseases, it is even more cogent as a ground for dissolution of marriage.

Paragraph (l) of the same section is a catch-all situation of any ground that is recognised as valid under Hukum Syara'. It is submitted that the ultimate threat to the life of the spouse and that of the foetus is sufficient as a ground for fasakh. If the spouse concerned is the husband, it is so much easier under Islamic family law as the man need not state the reason why he is pronouncing the talaq, thus effecting a divorce. A divorce by talaq is governed by section 47 of Act 303.

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58 Ibid, section 52(1).

59 Ibid, section 52(1)(l).

The writer accedes that the discussion above regarding grounds for divorce would not constitute the basis for creating a duty on the part of the HIV infected spouse to inform his/her spouse of his/her seropositivity. The legal position discussed above merely look at the possible consequence of such a non-disclosure i.e. divorce. The moral argument put forward is to strengthen the argument that there should be such a duty or obligation as it goes to the very root of the marriage. It is not the intention of the writer to encourage divorce amongst those whose spouses are HIV antibody positive. In fact, it is acknowledged that those in such a situation need the support, love and understanding of each other to brave through such a traumatic situation.

C. Criminal Law

One of the traditional responses of the legal system to curb the spread of infectious disease and inculcate individual responsibility is by the operation of the criminal law. This can be seen in past responses to diseases such as Hansen's disease (leprosy) and tuberculosis. With HIV, the risk of serious actual harm to individuals invoke another reason for resorting to criminal law in the attempt to prevent and control the spread of HIV - protection of individual from harm. The State therefore has the responsibility to prevent and control such a catastrophe.

As such the other possible legal consequences of the failure to inform the partner of one's seropositivity lies in the realms of criminal law which is governed mainly by the Penal Code.[60] This is subject to the stand that non-disclosure contributes to the spread of the HIV infection.

1. Section 269, Penal Code

Negligent act likely to spread infection of any disease dangerous to life.

> Whoever unlawfully or negligently does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life, shall be punished with imprisonment for a term which may extend to six months, or with fine, or with both.

The section requires an unlawful or negligent act on the part of the accused. Can the act of the person with HIV infection of not informing his partner of his seropositivity amount to an unlawful or negligent act? The term 'illegal' is defined under section 43 of the Penal Code as applicable to everything which is an offence, or which is prohibited by law, or which furnishes ground for a civil action.

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60 FMS Cap 45.

Under the Prevention and Control of Infections Diseases Act 1988[61], section 12(2) states:

> No person who knows or has reason to believe that he is suffering from [Human Immunodeficiency Virus Infection (All forms)] shall do any act which he knows or has reason to believe is likely to lead to the spread of such infectious disease.

A contravention at this section amounts to an offence.[62] Thus so long as the person does any act[63] which he knows or has reason to believe is likely to lead to the spread of the HIV infection, he has committed an unlawful act as required under section 269 of the Penal Code. The term 'act' seems to connote a positive action rather than an omission. It would thus cover actions such as the continuation of unprotected sexual relations or the sharing of injection equipment without taking the necessary steps to disinfect them. However, section 32 of the Penal Code extends it to include illegal omissions. One therefore has to decide whether the omission to inform the partner of his seropositivity is

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61 Act 342.

62 Ibid, section 12(3).

63 Emphasis is mine.

an illegal omission. The word 'negligently' has been taken to mean omitting or neglecting to do something which ought to have been done.[64] This would encompass the omission to inform the partner of one's seropositivity.

In addition to the act, the accused must also know or has reason to believe that his act is likely to spread the infection of any disease dangerous to life. The term 'reason to believe' is defined under section 26 of the Penal Code which states that:

> A person is said to have 'reason to believe' a thing, if he has sufficient cause to believe that thing, but not otherwise.

Thus the person must be shown to have knowledge that the disease was infectious. In a situation where the disease is generally known to be infectious there will be no difficulty in this aspect. In Malaysia, an identified HIV-infected person is given counselling as to inter alia, the nature of the infection and its modes of transmission. It would therefore be of no defence to a person so counselled to claim that he has no knowledge or has no reason to believe that his act of unprotected sexual intercourse, for example, is likely to spread HIV infection.

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64 (1909) 10 Cri LJ 293 (293)(Mad).

2. Section 270, Penal Code

Malignant act likely to spread infection of any disease dangerous to life.

> Whoever malignantly does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life, shall be punished with imprisonment for a term which may extend to two years, or with fine, or with both.

The only difference between section 269 and section 270 is the use of the word 'malignantly' instead of 'unlawfully or negligently'. The word 'malignantly' denotes a deliberate intention on the part of the accused to do harm. The term is not defined in the Code but is used in the sense of 'maliciously'. The word 'malice' is commonly accepted as ill-will against a person but in the legal sense means a wrongful act, done intentionally, without just cause or excuse.[65] There is thus an additional requirement of intention to do the act without just cause or excuse under section 270 of the Penal Code.

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65 Bromage v Prosser (1825) 4 B & C 247, per Bayley J at p 255.

3. Section 12(2), Prevention and Control of Infectious Diseases Act 1988

> Section 12(2).
>
> No person who knows or has reason to believe that he is suffering from [Human Immunodeficiency Virus Infection (All forms)] shall do any act which he knows or has reason to believe is likely to lead to the spread of such infectious disease.

The two sections under the Penal Code as mentioned above can be distinguished from section 12(2) of the Prevention and Control of Infectious Diseases Act 1988.[66] This section is a specific provision passed by the Legislature in an attempt to prevent and control the spread of HIV infection. Contravention of section 12(2) is an offence[67] and carries a penalty of an imprisonment for not more than two years or fine or both for a first offence. A second and subsequent offence carries an imprisonment term not exceeding five years or fine or both. A continuing offence is subject to a further fine not exceeding two hundred ringgit for every day during which the offence continues.[68]

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66 Act 342.

67 Ibid, section 12(3). Any person who contravenes this section commits an offence.

68 Ibid, section 24(a), (b) and (c).

Section 12(2) has done away with the requirement of the act being qualified by its being unlawful, negligent or malignant as in section 269 and section 270 of the Penal Code. So long as that person knows or has reason to believe that he is suffering from HIV infection, he is obliged under this section not to do any act which he knows or has reason to believe, is likely to lead to the spread of HIV infection. In the light of the current national programme on the Prevention and Control of AIDS under the Ministry of Health where counselling is rendered to the HIV infected person, it would be easier to apply this section if and when the need arises as that person can no longer plead ignorance as a defence as can be done if that person is charged under section 269 or section 270 of the Penal Code.

4. Offences affecting human body

Where there is an infection as a result of the non-disclosure and exposure to the risks of infection i.e. unprotected sexual intercourse, the infection may amount to offences affecting the human body as listed under Chapter XVI of the Penal Code.[69]

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69 FMS Cap 45.

(a) Sections 321 and 322.

The person who infected others may be charged for voluntarily causing hurt or grievous hurt under section 321 and section 322 respectively. Section 319 states that whoever causes bodily pain, disease or infirmity to any person is said to cause hurt. Section 320 on the other hand listed down the various kinds of grievous hurt:

Section 320.

The following kinds of hurt only are designated as 'grievous':

First	-	Emasculation.
Secondly	-	Permanent privation of the sight of either eye.
Thirdly	-	Permanent privation of the hearing of either ear.
Fourthly	-	Privation of any member or joint.
Fifthly	-	Destruction or permanent impairing of the powers of any member or joint.
Sixthly	-	Permanent disfiguration of the head or face.
Sevently	-	Fracture or dislocation of a bone.
Eightly	-	Any hurt which endangers life, or which causes the sufferer to be, during the space of twenty days, in severe bodily pain, or unable to follow his ordinary pursuits.

HIV infection per se would not be sufficient if the person who causes the infection is to be charged for either voluntarily causing hurt or grievous hurt.[70] It is only when it progresses further and causes bodily pain, disease or infirmity that it falls under the definition of 'hurt'. It can only be grievous hurt if such bodily pain, disease or infirmity engangers life as stated under the eight designation of 'grievous' under section 320.

As such, whether a person who has infected another is to be charged for voluntarily causing hurt or grievous hurt would depend on the state of health of the infected person. If the person infected is only suffering bodily pain, disease or infirmity, it would fall under section 319. However, if it has reached the stage where such hurt endangers his life i.e. AIDS sufferer it would be more appropriate to charge him under section 320 of the Penal Code.

This imposes the prequisite of mens rea in the form of intention, knowledge or reason to believe. Section 26 of the Penal Code define reason to believe, as having 'sufficient cause to believe that thing, but not otherwise.'.

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70 The term 'voluntarily' is defined under section 39 of the Penal Code:

> A person is said to cause an effect 'voluntarily' when he causes it by means whereby he intended to cause it, or by means which, at the time of employing those means, he knew or had reason to believe to be likely to cause it.

If a person donates blood infected with HIV with the intention of causing such an infection or with the knowledge or reason to believe that it would cause such an infection the person who receives the blood, the blood donor is then liable to be charged under either section 321 or 322 of the Penal Code. Which section it falls under would depend on the state of health of the infected person as discussed in the paragraph above.

Similarly, if a person knowing that he is HIV-antibody positive, have unprotected sexual intercourse with his spouse and the spouse gets infected, he may be charged under either section 321 or 322 of the Penal Code.

(b) Section 334 and 335

The element of provocation where hurt and grievous hurt have been caused, is taken into consideration in both sections 334 and 335.

> Section 334 Voluntarily causing hurt on provocation.
>
> Whoever voluntarily causes hurt on grave and sudden provocation, if he neither intends nor knows himself to be likely to cause hurt to any person other than the person who gave the provocation, shall be punished with imprisonment for a term which may extend to one month, or with fine which may extend to one thousand ringgit, or with both.

Section 335 Causing grievous hurt on provocation

Whoever voluntarily causes grievous hurt on grave and sudden provocation, if he neither intends nor knows himself to be likely to cause grievous hurt to any person other than the person who gave the provocation, shall be punished with imprisonment for a term which may extend to four years, or with fine which may extend to four thousand ringgit, or with both.

However, the person concerned must neither intend nor know that he would be likely to cause hurt to any person other than the person who provoked him. Three provisoes are applicable to these sections:[71]

Firstly - That the provocation is not sought or voluntarily provoked by the offender as an excuse for killing or doing harm to any person.

Secondly - That the provocation is not given by anything done in obedience to the law, or by a public servant in the lawful exercise of the powers of such public servant.

Thirdly - That the provocation is not given by anything done the lawful exercise of right of private defence.

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71 Penal Code, section 300, Exception 1.

(c) Sections 324 and 326

> Section 324 Voluntarily causing hurt by dangerous weapons or means.
>
> Whoever, except in the case provided for by section 334, voluntarily causes hurt by means of any instrument for shooting, stabbing, or cutting, or any instrument which, used as a weapon of offence, is likely to cause death, or by means of fire or any heated substance, or by means of any poison or any corrosive substance, or by means of any explosive substance, or by means of any substance which it is deleterious to the human body to inhale, to swallow, or to receive into the blood, or by means of any animal, shall be punished with imprisonment for a term which may extend to three years, or with fine, or with whipping or with any two of such punishments.

Section 326 is a similar provision with regards to grievous hurt and carries a heavier penalty of imprisonment which may extend to twenty years and fine or whipping.

Both sections 324 and 326 pertain to voluntarily causing hurt and grievous hurt by dangerous weapon. These sections is only applicable where a dangerous weapon is used. The relevant part under the provisions has been underlined above. Thus where the hurt or grievous hurt was caused by means of introduction of the virus into the blood, such as via an injection-sharing equipment, transplantation of infected body organs or even unprotected sexual intercourse, these sections may be utilised to charge the offender. However, in

addition to the element of 'voluntarily' causing hurt and grievous hurt,[72] the application of sections 324 and 326 revolves around the interpretation of 'dangerous weapons or means'. It is submitted that since the reception of HIV into the blood undermines the body's immune system, it is 'deleterious' to the human body.

(d) Section 336, 337 and 338

A rash or negligent act on the part of an infected person which endangers the life and personal safety of others may come under section 336 which states:

> Whoever does any act so rashly or negligently as to endanger human life or the personal safety of others, shall be punished with imprisonment for a term which may extend to three months, or with fine which may extend to five hundred ringgit, or with both.

This is a general provision with no limitation in terms of time factor or type of danger. Whether or not section 336 applies in any particular situation depends on the definition of 'rashly or negligently'. The former suggests thoughtlessness whereas the latter is more of carelessness. Can a person who knows himself to be infected with HIV be said to be rash or

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72 Refer to discussion in 4(a) at pp. 154-156.

negligent if he renders cardio-pulmonary resuscitation to the victim of a car accident? The other element is whether such an act endangered the life or personal safety of others. Would the act of rendering assistance to revive or sustain the breathing of the victim endanger the life or personal safety of the victim or others?

It is to be noted that there need not be actual harm under this section. So long as the said act was done so rashly or negligently as to endanger human life or the personal safety of others, it is sufficient. Thus the mere existence of risks to the life or personal safety of others would be enough.

Section 337 and 338 deal with causing hurt and grievous hurt by a rash or negligent act which endangers life or the personal safety of others.

> Section 337 Causing hurt by a act which endangers life or the personal safety of others.
>
> Whoever causes hurt to any person by doing any act so rashly or negligently as to endanger human life, or with the personal safety of others shall be punished with imprisonment for a term which may extend to six months, or with fine which may extend to one thousand ringgit or with both.
>
> Section 338 Causing grievous hurt by an act which endangers life or the personal safety of others.
>
> Whoever causes grievous hurt to any person by doing any act so rashly or negligently as to endanger human life or the personal

> safety of others, shall be punished with imprisonment for a term which may extend to two years, or with fine which may extend to two thousand ringgit, or with both.

In addition to the element of such rash or negligent act which endangers the life or personal safety of others, both the sections require actual harm, be it hurt[73] or grievous hurt.[74]

If the element of intention to cause death or such bodily injury as is likely to cause death is present, the offence may be one of culpable homicide or murder.[75] This would only come into play where death has occurred. The provisions however would be redundant if the person who infect others is himself dead. As is known, once a person develop AIDS, his life span is significantly reduced in accordance with the various infections and cancers which he suffers. Thus, it would be a moot issue whether that person can be charged for murder because that person has to be alive by the time the person he infected is dead.

In all the situations mentioned above, one of the problems that would be encountered is to prove the mens rea

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73 Penal Code, Section 319.

74 Ibid, section 320.

75 Section 299 and section 300 of Penal Code. Both these sections will be discussed in Chapter V.

required under the respective sections. In addition, there may be situations where the accused had not intended nor know that the act would be likely to cause death or grievous hurt. The defence of consent and good faith on the part of the doer may arise in various situations especially where the doer is ignorant of his own seropositivity. Such a situation would constitute a general defence as stated under section 87 of the Penal Code.

> Nothing, which is not intended to cause death or grievous hurt, and which is not known by the doer to be likely to cause death or grievous hurt, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, to any person above eighteen years of age, who has given consent, whether express or implied, to suffer that harm; or by reason of any harm which it may be known by the doer to be likely to cause to any such person who has consented to take the risk of that harm.

This of course requires proof that the person infected had in fact consented to suffer that harm. The consent may be express or implied. It is highly unlikely that a person would consent to being infected by HIV in view of the fact that it is lifelong, may develop into AIDS and that it has no cure or vaccine. More often than not the 'consent' may be vitiated by lack of information or knowledge of the person's seropositivity.

5. Conclusion

As can be seen from the above discussion, there are several provisions under the Penal Code[76] that may be utilised in prosecuting a person who has infected another. This however, is dependent on a few factors:

(1) whether he is still alive;

(2) the extent of injury suffered by the other party;

(3) whether he was aware of his HIV status;

(4) whether he had the intention to cause such injury on the other party;

(5) whether the other party knew of his seropositivity.

(6) whether the other party consents to the risk of being infected.

The circumstances under which the infection occurred need also be identified so as to enable one to decide which provision it comes under.

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76 FMS Cap 45.

It is noted that the aim of criminal law would be at variance with that of the National Prevention and Control Programme on AIDS. The former seeks to punish the individual by imposing imprisonment and fine whereas the latter seeks to prevent and control the spread of the HIV infection by offering counselling and various support activities to the individuals concerned. This is because the cooperation and understanding of those infected are crucial to the prevention and control of the infection as acknowledged by the WHO.

The wisdom of criminalising the act of spreading the HIV infection has been questioned by various quarters especially non-governmental groups and various governments the world over. The various international consultations at the instance of the WHO lend support to the argument against criminalising the whole issue as much more is at stake as opposed to the need to penalise the person concerned. It involves public health and society. Thus it cannot be individually tackled by punishing those individuals on an ad hoc basis.

Unfortunately, although this is acknowledged by the Ministry of Health, section 12(2) of the Prevention and Control of Infectious Diseases Act 1988[77] criminalises the act 'which

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77 Act 342.

he knows or has reason to believe is likely to lead to the spread of [HIV infection]'. Contravention of the said section is an offence[78] and carries with it the penalty of imprisonment or fine or both.[79] Although this section is not likely to be used in view of the fact that it contradicts the broader aim of the National Programme of Prevention and Control of AIDS, the said provisions have been described as necessary, just in case it is needed. There is thus the power to punish the 'offenders' if need be. This section however has never been utilised to the extent of prosecuting a person in court.[80] Although the practicality of the section is questionable, it was nevertheless included in the said Act as a safeguard. Whether this 'safeguard' is of any practical sense and value in the scheme to prevent and control HIV infection is left to be seen.

There have been however, convictions in relation to the offence of the spreading the HIV in other countries. The first case to fall under a 1987 AIDS-specific Louisiana law was the conviction of a man who knowingly transmitted the virus to his unsuspecting girlfriend. The law makes it a crime to

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78 Ibid, section 12(3).

79 Ibid, section 24(a), (b) and (c).

80 Confirmed by Dr Jit Singh of the Ministry of Health.

intentionally expose anyone to the AIDS virus.[81] The Denmark's law against recklessly endangering another person's life has also been used in an AIDS-related case. A street musician who is a HIV-carrier was sentenced to 18 months in prison and ordered to pay compensation to the two minors he had sex with. He had failed to use a condom during sex acts with 23 women and two minors. None of the partners has been infected.[82] Another case where a person is charged for reckless endangerment of another person's life has been reported in Tennessee. In this case, the fiancee of an AIDS sufferer was so charged because she let a bystander give the 'kiss of life' to her fiancee as he lay dying from a heart attack.[83]

The discussion above focussed on the conduct of the HIV-infected individual which may amount to a crime under the provisions of the Penal Code. There have been various calls for provision to cover specific crimes in order to penalise the deliberate or reckless spread of this potentially lethal virus.[84]

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81 "Man found guilty of spreading AIDS", New Straits Times, November 20, 1992, at p 23.

82 "Jailed for unsafe sex - HIV man had 23 sex partners", The Malay Mail, March 13, 1993, at p 9.

83 "AIDS victim's fiancee on 'kiss of death' charge", New Straits Times, June 29, 1991.

84 See e.g. DJ Besharov 'Make it a Crime to Spread AIDS'. Washington Post, 18 Oct 1987, D5 and M Barnard, 'Curtail Sexual Threat by Law', Melbourne Age, 22 March 1988, 13.

Responding to such calls, a number of Australian states, for example, have enacted laws providing a specific penalty in the case of unprotected sexual intercourse by infected persons. In New South Wales, a person who knows he has a proclaimed disease (which includes AIDS) may not have sexual intercourse with another person unless the other person has been informed of the risk of contracting the disease from that person prior to the intercourse and the other person has voluntarily agreed to accept the risk. A maximum fine of $5,000 is liable to be imposed.[85] In Victoria, amendments to the Health Act in 1987 provided a fine of up to $20,000 for a person who deliberately infects another with AIDS or any other infectious diseases.

A similar response locally is section 12 of the Prevention and Control of Infectious Diseases Act 1988[86] which makes it an offence for an HIV-infected person to do any act which he knows or has reason to believe is likely to lead to the spread of HIV.[87] The penalty is imprisonment for not more than two years or fine or both for a first offence.[88] Although this provision has not been fully utilised, there may come a time when a person may actually be charged under section 12(3)

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85 Public Health (Proclaimed Diseases) Amendment Act 1985, s 3 [inserting s 50N(3) in the Public Health Act 1902 (NSW)]

86 Act 342.

87 Ibid, section 12(2) and (3).

88 Ibid, section 24(a).

of the said Act. It has been reported that there are some drug addicts in the drug rehabilitation centres in the country 'who are bent on revenge' and would intentionally infect others once they are out of the centres.[89]

Laws such as section 12(2) of the Prevention and Control of Infectious Diseases Act 1988[90] should generally be seen as being symbolic rather than having any practical value. The penalty per se would not curtail the spread of HIV. Proof and enforcement of the section would be extremely difficult. By the time the matter is prosecuted upon, the offender may be dead or very ill. Proof that it was he who caused the infection may be extremely difficult. The lack of resources on the part of the prosecution to find sufficient proof to enforce the provisions would curtail any effort of utilising these provisions. Furthermore, it is acknowledged that imprisonment is not the solution to curb the spread of HIV. In fact, it may be the reverse. The problem of overcrowding in prison is another factor to be considered. A person suffering from AIDS would be in need of medical attention and such attention can only be provided in hospitals, not prisons. It can be

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89 The New Straits Times, 10th December 1992, 'All is not well at rehab centres' at pp 25 and 33.

90 Act 342.

concluded that the existence of the penal provisions discussed above especially section 12(2) of the Prevention and Control of Infectious Diseases Act 1988[91] are more of a symbolic rather than practical value.

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91 Ibid.

CHAPTER V

OTHER RELATED CRIMINAL ISSUES

A. Euthanasia[1]

The controversy surrounding euthanasia or commonly referred to as 'mercy killing', is the fact that as the law stands, sanctity of life is given utmost priority, even in the case of a terminally ill patient. There is no legal provision in Malaysia allowing euthanasia (and most probably there will not be such legislation in the foreseeable future) even though in certain states in Australia, for instance, euthanasia is permitted, albeit regulated.[2]

The term euthanasia literally means a good death.[3] Over the years, however, the meaning has been somewhat modified. The term 'euthanasia' when applied today basically

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1 Black's Law Dictionary, 6th ed., St Paul Minn., West Publishing Co., 1990 defines 'euthanasia' as the act or practice of painlessly putting to death persons suffering from incurable and distressing disease as an act of mercy.

2 The latest is Holland where it is permitted per se unless conditions are not complied with.

3 From the Greek words eu-thanatos.

means that a terminally ill patient is being assisted, upon his request and with his consent, to end his life. The assistance rendered may be passive or active and usually rendered by the doctor. Passive euthanasia is to bring about the death of the patient by withholding or withdrawing treatment which sustains life, in conditions where the resultant death is indeed easy, painless, dignified and quick. Active voluntary euthanasia on the other hand involves active participation by the doctor in the rapid and painless inducement of death, usually using a drug or gas, at the patient's request and direction.

The patient who has an incurable disease is distinguished from one who is terminally ill. In the former, an HIV infected person can be so categorised as there is, thus far, no vaccine for the infection. A terminally ill patient however is limited to the infected person who had reached the stage where his condition is terminal. This encompasses those who have developed full-blown AIDS. The following discussion on euthanasia in the various situations applies only to the terminally ill.

A doctor, in his dealing with AIDS patients may be faced by several possible scenarios. The patient may request outright that he be given 'something' so that he could die then and there, without waiting for his condition to worsen. Here the doctor may not assist such an action as it amounts to

abetting suicide in the least and murder at its worst.[4] The patient is still relatively healthy and can lead a relatively normal life except for the various minor infections that is common at that stage. It is the doctor's duty to ensure that the patient be treated for such ailments as treatment can still be rendered.

At the stage where minor infections persist and major infection sets in due to the weakened immune system in the body, the patient may again request for assistance to relieve pain and even to end his life as he knows it will only get worse. Although the patient's condition has worsened, the doctor is still obliged to treat i.e. to render medication for the pain and to proceed with the treatment of the infections. To do otherwise may amount to committing certain offences such as abetting suicide, abetting murder or even murder itself.

Finally, the patient may have discussed the possibility of withholding or withdrawing treatment when he reaches the terminal stage and may have expressed his wish that such be the case. Or he may only request for it when he has reached the terminal stage. Another common situation is where no prior discussion or consultation was held between the patient

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4 These will be discussed later in this Chapter.

and the doctor. Here, the doctor is left with the dilemma of making that decision for the patient. This last scenario would not be within the scope of the discussion on euthanasia as the element of 'voluntariness' is absent on the part of the patient whose life is at stake. It is only in the other two situations that the issue of euthanasia arises. The issues surrounding euthanasia result from the conflicting ethical/legal principles governing the doctor-patient relationship.

These include sanctity of life, compassion, non-maleficience and autonomy. From the ethical aspects, there may be conflicts confronting the doctor. Should he prolong the life of the said patient or should he respect the patient's wishes and act, out of compassion, to reduce pain and suffering and allow the patient to die with dignity?

The World Medical Association have considered the matter and issued the statement below:

> "Euthanasia, that is the act of deliberately ending the life of a patient, either at his own request, or at the request of his close relatives is unethical. This does not prevent the physician from respecting the will of the patient to allow the natural forces of death to follow its course in the terminal phase of sickness."[5]

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5 World Medical Association, 1987, Lancet (i), 1505.

The above statement distinguishes between active and passive euthanasia, condemning the former and allowing the latter. The autonomy of the patient seem to have prevailed only in the second instance. The stand on active euthanasia seems to have stemmed from the principle of non-maleficence. Thus, even when the patient himself requests for an ending of his life using the principle of autonomy, the doctor's duty to do no harm based on non-maleficence overrides the autonomy, making the doctor's participation in such a scheme unethical. The principle of sanctity of life is so deeply entrenched in medical ethics that anything contrary to it is deemed to be inflicting harm. This can be traced in the various ethical codes. In the Hippocratic Oath, it is declared:

> ... To please no one will I prescribe a deadly drug, nor give advice which may cause his death ...

The Declaration of Geneva affirm this by stating:

> ... I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity ...

The duties of doctors to the sick is laid down in the International Code of Medical Ethics as:

> A doctor must always bear in mind the obligation of preserving human life.

Should the sanctity of life be upheld at all times? Although it is conceded that preserving human life is an obligation of the doctor, it has been questioned by some doctors themselves. Must a patient who is at the brink of death, with no hope of recovery, be treated at all costs so as to 'preserve his life'? It is actually more accurate to say that it is 'postponing the death' in such a situation.

It is submitted that the ethical principle of compassion would intervene at such a stage because when the patient has reached the terminal stage, the doctor's duty is modified to one of providing comfort and relief from pain. Subsequently, the doctor may respect the will of the patient 'to allow the natural forces of death to follow its course' by withholding or withdrawing the life-sustaining treatment. This would be in line with the stand taken by the World Medical Association.

Unfortunately, this does not mean that legally, the issues are resolved. Legal issues associated with euthanasia come under criminal law. They encompass attempted suicide, abetment of suicide, murder, culpable homicide, abetment of murder and abetment of culpable homicide. The criminal law in Malaysia is governed by the Penal Code[6].

The present law on these offences will be looked at to assess their applicability to euthanasia in terminal AIDS cases.

B. Suicide

Section 309 of Penal Code — Attempt to commit suicide

> Whoever attempts to commit suicide, and does any act towards the commission of such offence, shall be punished with imprisonment for a term which may extend to one year, or with fine, or with both.

Section 306 of Penal Code — Abetment of suicide

> If any person commits suicide, whoever abets the commission of such suicide shall be punished with imprisonment for a term which may extend to ten years, and shall also be liable to fine.

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6 FMS Cap. 45.

The term 'suicide' has not been defined under the Code. The application of the above provisions in the case of euthanasia would depend on whether euthanasia fall within the meaning of suicide. Suicide is the deliberate self-destruction or the taking of one's own life. Euthanasia may fall under the category of suicide - although the circumstances leading to such an action is confined to terminally ill patients whereas suicide normally involves those who are physically healthy but are emotionally distressed. If it is decided that euthanasia amounts to suicide, then the doctor concerned may be charged under section 306 of the Penal Code which carries the penalty of imprisonment for a term which may extend to ten years and also liable to fine.

Aiding the patient in euthanasia cases such as withdrawing the life-support system may then amount to abetment as defined under section 107 of the Penal Code.

Section 107
of Penal Code Abetment of a thing

A person abets the doing of a thing who -

First:

Instigates any person to do that thing; or

Secondly:

Engages with one or more other person or persons in any conspiracy for the doing of that thing, if an act or illegal omission takes place in pursuance of that conspiracy, and in order to the doing of that thing; or

Thirdly:

Intentionally aids, by any act or illegal omission, the doing of that thing.

Explanation 2 Whoever, either prior to or at the time of the commission of an act, does anything in order to facilitate the commission of that act, and thereby facilitates the commission thereof, is said to aid the doing of that act.

The third part of section 107 seem to be most relevant in the context of the discussion on AIDS patients i.e. abetment by aid. It would cover the situation where the doctor assists the patient to commit suicide.

Two elements need to be proved in such a situation. Firstly, that the doing of the act should actually be aided. Secondly, that the aid was rendered with the intention of

aiding the said act.[7] In the case of National Coal Board v Gamble[8], it was stated by Devlin J:

> A person who supplies the instrument for a crime of anything essential to its commission aids in the commission of it; and if he does so knowingly and with intent to aid, he abets it as well and is therefore guilty of aiding and abetting.[9]

Thus, where the doctor provides or allows the patient access to any drug or equipment which can be used by the patient to commit suicide, with the intention of facilitating the suicide, he is guilty of abetment of suicide.

Where the patient wishes to die and asks to be assisted to die, it is clear that the doctor is under no duty to comply with such a demand. The doctor who complies with such a request may be charged for abetment of suicide. It is immaterial whether the suicide was successful or whether it was committed at all. This is stated in Explanation 2 of section 108 of Penal Code:

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7 R v Clarkson [1971] 3 All ER 344.

8 [1959] 1 QB 11.

9 Ibid, at p 20.

> To constitute the offence of abetment, it is not necessary that the act abetted should be committed, or that the effect requisite to constitute the offence should be caused.

Since there are no local cases directly in point, reference will be made to recent American cases.

The American case of Dr. Jack Kevorkian falls under this category. The retired pathologist has been involved in the suicides of several women, starting in June 1990, using either lethal drugs or carbon monoxide gas. The first three cases were in Michigan which has no law against assisted suicide.10 The murder charges against him in the first three deaths he assisted in were thrown out by the judges. The latest case involved 46 year old Catherine Andreyes who was suffering from cancer that had spread throughout her body.[11] A device that allowed her to inhale carbon monoxide gas through a face mask was hooked up so she could turn it on herself, which was what she did. All the five suicides involved people with terminal or painful illnesses who killed themselves with devices or materials the 63 year old retired pathologist supplied.

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10 'Suicide Doctor', The Star, February 7, 1992 at p. 21.

11 'Suicide Doc At It Again', The Malay Mail, November 24, 1992 at p. 9.

These cases sparked off anew the debate on euthanasia in the United States. The state of Washington recently held a statewide ballot on euthanasia in the form of Initiative 119.[12] Initiative 119 would make Washington the first state in the world to pass a law authorising doctors to assist in suicides or give lethal injections to patients who have asked to die.

C. Murder, culpable homicide

Euthanasia is culpable homicide and may also amount to murder. Culpable homicide is stated under section 299.

Section 299 Culpable homicide

> Whoever causes death by doing an act with the intention of causing death, or with the intention of causing such bodily injury as is likely to cause death, or with the knowledge that he is likely by such act to cause death, commits the offence of culpable homicide.

Explanation 1 A person who causes bodily injury to another who is labouring under a disorder, disease, or bodily infirmity, and thereby accelerates the death of that other, shall be deemed to have caused his death.

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12 "The Ethics of Helping Others Die." The Malay Mail, October 30, 1991, at p. 36.

So long as there is an intention to cause death or that there is knowledge that such an act is likely to cause death, the offence of culpable homicide is committed. It may amount to murder if it satisfies the elements required under section 300 of the Penal Code.

Section 300 Murder

> Except in the cases hereinafter excepted, culpable homicide is murder, if the act by which the death is caused is done with the intention of causing death, or
>
> Secondly - If it is done with the intention of causing such bodily injury as the offender knows to be likely to cause the death of the person to whom the harm is caused, or
>
> Thirdly - If it is done with the intention of causing bodily injury to any person, and the bodily injury intended to be inflicted is sufficient in the ordinary course of nature to cause death, or
>
> Fourthly - If the person committing the act knows that it is so imminently dangerous that it must in all probability cause death, or such bodily injury as is likely to cause death, and commits such act without any excuse for incurring the risk of causing death, or such injury as aforesaid.

Under the fourth clause of section 300, intention to cause death or knowledge that such act act is so imminently dangerous that it must in all probability cause death is sufficient to satisfy section 300. The test of the second limb of the said clause is laid down in William Tan Cheng Eng v Public Prosecutor.[13] It was held by the Court of Criminal Appeal that it is not sufficient to amount to murder under section 300 for an act to be so imminently dangerous that it must in all probability cause death. Such an act becomes murder only if the person who commits it knew when commiting the act, that it was so imminently dangerous that it would in all probability cause death or such bodily injury as is likely to cause death.[14] There must be such knowledge. Thus, a doctor who does any act with the intention to cause death or with the knowledge that his act would cause the death of his patient may be charged for murder.

In addition to the above, it must be proved that the death resulted from the said act. The death must be caused by the act in question, not any supervening event. If there is a break in the chain of causation, the prosecution would be unable to prove the charge.

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13 [1970] 2 MLJ 244.

14 Ibid, at pp 245 and 246.

Can the doctor who, with the patient's consent, disconnects the life-support system of the terminally ill patient be said to have caused his death? The fact that the said patient is terminally ill should be taken into consideration in deciding whether the doctor's action actually caused the death. Is the mere hastening of the inevitable death in such a case the cause or is the disease itself the actual cause?[15]

An issue that may arise in euthanasia concerns the consent of the patient. Can consent of the patient be a defence to the charge of murder against the doctor?[16] A look at Exception 5 to section 300 would be of assistance here.

> Exception 5 Culpable homicide is not murder when the person whose death is being caused, being above the age of eighteen years, suffers death, or takes the risk of death with his own consent.

Exception 5 to section 300 of the Penal Code merely reduces it to an offence of culpable homicide not amounting to murder where the person whose death is being caused, being above

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15 R v Cunningham [1982] AC 566. See infra, p 191.

16 See infra, p 194.

eighteen years of age, consented to the said act.[17] A person below eighteen years old is deemed incapable, under the law, to consent to his own death.[18]

Illustration A, by instigation, voluntarily causes Z, a person under eighteen years of age, to commit suicide. Here, on account of Z's youth, he was incapable of giving consent to his own death. A has therefore abetted murder.

It appears that consent by a person above eighteen would be taken into consideration. The drafters of the Code gave the following reasons for not punishing homicide by consent so severely as murder:

> In the first place, the motives[19] which prompt men to the commission of this offence are generally far more respectable than those which prompt men to the commission of murder. Sometimes it is the effect of a strong sense of religious duty, sometimes, of a strong sense of honour, not unfrequently of humanity. The soldier who, at the entreaty of a wounded comrade, puts that comrade out of pain, the friend who supplies laudanum to a person suffering the torment of a lingering disease ... would, except in Christian

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17 'Consent' is defined under section 90 of the Code.

18 Illustration to Exception 5, section 300, Penal Code.

19 Emphasis is mine.

> societies, scarcely be thought culpable, and even in Christian societies would not be regarded by the public, and ought not to be treated by law, as assassins.[20]

Therefore, where the patient who is above eighteen years of age consents to suffer death or take the risk of death such as in terminating life support system or being given drugs to reduce the pain suffered with the consequence of accelerating death, Exception 5 may be pleaded. This however, merely reduces the offence to one of homicide not amounting to murder.

The application of Exception 5, section 300 of the Penal Code can be seen in the case of Kanaga Kosavan[21] where the court held that the Exception applies when the court can hold that it is not impossible that the deceased feeling desperate and depressed, asked to be killed and no motive is proved against the accused for deliberately killing the deceased of his own free will.

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20 Ratanlal and Dhirajlal's, Law of Crimes, 23rd ed. Vol. 2, Bharat Law House, New Delhi, 1988, at p 1115.

21 (1930) 54 Mad 504.

Another provision regarding consent is section 87 of Penal Code:

Section 87 Act not intended and not known to be likely to cause death or grievous hurt, done by consent.

Nothing, which is not intended to cause death or grievous hurt, and which is not known by the doer to be likely to cause death or grievous hurt, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, to any person above eighteen years of age, who has given consent, whether express or implied, to suffer that harm; or by reason of any harm which it may be known by the doer to be likely to cause to any such person who has consented to take the risk of that harm.

To successfully plead this general defence, it must be shown, in addition to consent, that the act was not intended and not known to be likely to cause death or grievous hurt. In the context of euthanasia, it is highly unlikely that the doctor concerned do not know that the act concerned would cause death.

In cases of unsuccessful euthanasia, where death is not the actual consequence of the act even though the element of intention or knowledge was present, the offence is one of attempt to murder as laid down under section 307 or attempt to commit culpable homicide under section 308.

Section 307 Attempt to murder

> Whoever does any act with such intention or knowledge and under such circumstances, that if he by that act caused death he would be guilty of murder, shall be punished with imprisonment for a term which may extend to ten years, and shall also be liable to fine ...

Section 308 Attempt to commit culpable homicide.

> Whoever does any act with such intention or knowledge and under such circumstances that if he by that act caused death he would be guilty of culpable homicide not amounting to murder, shall be punished with imprisonment for a term which may extend to three years, or with fine, or with both; ...

In practical terms, these cases would be difficult to detect. As it is, it is doubtful if a doctor would be charged for murder or culpable homicide in situations where euthanasia is carried out, be it at the request of the patient or otherwise.[22] So far, no such cases have reached the courts. This is probably due to the fact that normally the relatives would be relieved that the patient has finally been put to rest after a prolonged period of pain and suffering and also the

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22 No field research was conducted in this area due to constraint of time. Reference to a project paper by Caroline T.K. Chin entitled Death and Dying : Euthanasia Revisited, PP 1983/84, fk 668 FUU 517 confirmed the writer's belief that passive euthanasia is practiced by doctors in Malaysia.

fact that the patient is expected to die anyway. The latter makes it extremely difficult to differentiate the cases where death has occurred. The culpability factor is also negligible where priority is given to relieving pain and suffering of patients who are at the terminal stage when there is no longer any hope of achieving whatever quality of life that is worth living for.

As there are no local cases in relation to euthanasia, English cases will be looked at. In R v Bodkin Adams[23], the doctor was charged for murder of one of his terminal patient, an eighty-one year old widow by administering high doses of and heroin as well as other sedatives with the intent to kill her. He was acquitted. In delivering the judgment, Devlin J commented:

> If the first purpose of medicine - the restoration of health - could no longer be achieved, there was still much for the doctor to do, and he was entitled to do all that was proper and necessary to relieve pain and suffering even if the measures he took might incidentally shorten life...[24]

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23 Unreported. Discussed in H. Palmer, 'Dr. Adams' Trial For Murder', [1957] Crim. LR 365.

24 Ibid, at p. 375.

Therefore, where the measures taken by the doctor was to relieve pain and suffering, the fact that it incidentally shortens life was held to be justifiable by the court. The reluctance to place any blame on doctors who found themselves in the unfortunate position of having to take such measures can also be seen in the recent case of Dr. Nigel Cox, a consultant rheumatologist at the Royal Hamshire Country Hospital in Southern England. He gave 70 year old Lilian Boyes who was terminally ill with acute rheumatoid arthritis a lethal injection of undiluted potassium chloride on August 16, 1991, after she begged him to be allowed to die. The Crown Court convicted him of attempting to murder a terminally ill patient and was given a suspended one year prison sentence. The General Medical Council (GMC) however, allowed him to continue practising medicine after considering the matter in a two-day hearing.[25] The GMC ruled that no further action should be taken against Cox, who had treated the patient for 13 years.

The sympathetic tone can be found in the statement of the GMC president Sir Robert Kilpatrick:

> The committee understands and respects the distress as suffered by doctors who have looked after a patient for a long time and who find that in the terminal stages of illness the patient suffers extreme pain.

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25 Reported in The Malay Mail, 18 Nov. 1992 at p. 10.

Although it was noted that that Cox's actions had been 'both unlawful and wholly outwith (outside) a doctor's professional duty to a patient, the president pointed out that the court in passing the sentence had 'tempered justice with mercy'. More importantly, it was concluded that Cox had acted in good faith 'to relieve her intolerable suffering by expediting her death'. The case has been widely seen as a land-mark case in the area of euthanasia.

It can be seen from this recent case that the medical profession itself has begun to take a more sympathetic stand towards doctors who had taken such actions as to relieve the pain and suffering of their terminally-ill patients. The public will also be most likely to condone such actions in certain cases.

The perception of some judges towards cases where the life-support system is disconnected by the doctor can be illustrated by the case of R v Cunningham[26]. In this case the defendant struck another man with a heavy chair in an unprovoked attack motivated by sexual jealousy, causing serious head injury. The victim was placed on the breathing machine which was later switched off. The victim died three days later.

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26 [1982] AC 566.

The action of switching off the life-support system in this case did not break the chain of causation. The defendant was charged for murder (not the doctor) and was convicted for it. It was affirmed by the Court of Appeal and the House of Lords. In setting out the facts, Lord Hailsham stated:[27]

> The victim died on October 8, 1979, when, in view of the fact that he was virtually already dead, the breathing machine on which he had been placed on October 5 was finally switched off. Kim's death was due to a fracture of the base of the skull and a subdural haemorrhage as the result of ... blows received from the appellant.

As such, it appears that there may be situations where the court is willing to accept the termination of life-support system and not attribute the cause of death to the action of terminating the life-support system. It is however, qualified by the phrase that the victim was 'virtually already dead'. Can it then be argued that the case of AIDS sufferers whose situation is such that death is imminent be included in the category of those who are 'virtually already dead'? If so, the act of terminating life-support system by the doctor would not then be considered as the cause of death. However, who is to determine that such is the case? What are the criteria to be fulfilled before one can be sure that the person is 'virtually already dead'?

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27 Ibid, at p 573.

D. Possible Defences

(1) Consent

Consent per se is no defence to the charge of murder. It merely reduces the offence to culpable homicide not amounting to murder. This is found under Exception 5 of section 300 which states:

> Exception 5 Culpable homicide is not murder when the person whose death is being caused, being above the age of eighteen years, suffers death, or takes the risk of death with his own consent.

In the English case of Attorney-General's Reference (No. 6 of 1980)[28] the Court of Appeal held that if a person is charged with inflicting 'actual bodily harm' upon another, the fact that the person harmed consented to it is no defence, unless the public interest requires that this consent should be a defence in the particular case. The principle of autonomy is thus to that extent ignored.

If a doctor acts with the intention of bringing about the death of the patient, the fact that he was acting to alleviate suffering or for some other exemplary motive, would not at present provide him with a defence to the charge of

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28 [1981] QB 715, [1981] 2 All ER 1057.

murder.[29] This would be the position in Malaysia. The element of intention would oust the application of section 87 of Penal Code as a general defence of consent.[30] As it is, there is no scope to forward an argument that the doctor's exemplary motive or even the compliance with medical ethics constitute a defence for the offence of culpable homicide or murder. The consent of patients in euthanasia would be ineffective.

(2) Necessity

If it can be proved that the act was carried out without any criminal intention to cause harm and in good faith for the purpose of preventing other harm to the patient, the defence of necessity can be pleaded. This is under section 81 of Penal Code:

> Nothing is an offence merely by reason of its being done with the knowledge that it is likely to cause harm, if it be done without any criminal intention to cause harm, and in good faith for the purpose of preventing or avoiding other harm to person or property.
>
> Explanation - it is a question of fact in such a case whether the harm to be prevented or avoided was of such a nature and so imminent as to justify or excuse the risk of doing the act with the knowledge that it was likely to cause harm.

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29 R v Hyam [1975] AC 55, 73.

30 See supra, p 186.

This defence may be forwarded but whether or not the court would accept it as applicable in euthanasia cases discussed above is left to be seen. It can only be successfully pleaded if one can convince the court that the act of terminating the life support system or the administration of high doses of drugs to relieve pain (which has the consequence of hastening death) is a lesser evil. Could an act out of compassion or respect of the patient's autonomy justify the overriding of the sanctity of life? Is it a necessity to relieve pain and suffering at the expense of the life concerned?

Can the elements under section 81 be satisfied? The act is usually done with the knowledge that it is likely to cause harm i.e. death but was it done without any criminal intention to cause harm? In other words, was it done with just cause or excuse? The answer would depend on whether relieving pain and suffering or respecting the wish of the patient can constitute just cause or excuse to the resultant death. Even if it was done in good faith, can the relief of pain and suffering justify the death?

It is doubtful that the courts would accept the defence of necessity under section 81 of the Penal Code where the charge is one of murder or culpable homicide. The sanctity of life of a person was upheld in Dudley and Stephens[31] even

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31 (1884) 14 QBD 273.

when the competing interest was the lives of two others. In this case, Dudley and Stephens, the accused, together with the deceased, a boy aged between seventeen and eighteen, were cast away in a storm on the high seas. They were in an open boat, drifting on the ocean and was probably 1,000 miles from land. On the eighteenth day, they had been without food for seven days and without water for five days. Dudley and Stephens decided to kill the boy so that their lives could be saved. On the twentieth day, Dudley with the assent of Stephens, killed the boy and they both fed on his flesh for four days. Upon these facts, the court found no proof of any such necessity that could justify the accused killing the boy even though the argument was that they would have otherwise starved to death. They were found guilty of murder as the defence of necessity was rejected by the court.

Another case where the defence was forwarded is The King v Bourne.[32] In this case, the obstetrical surgeon was indicted for procuring miscarriage of a girl. The girl concerned was fourteen years old at that time. The defence was that the operation was to save the life of the girl who became pregnant as a result of being raped. In summing-up the case to the jury, MacNaghten J. said:

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32 [1939] 1 KB 687.

> the burden rests on the Crown to satisfy you beyond reasonable doubt that the defendant did not procure the miscarriage of the girl in good faith for the purpose only of preserving her life.[33]

The learned judge further explained that 'preserving the life of the mother' ought to be construed in a reasonable sense:

> ... if the doctor is of the opinion that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck, ... [he] is operating for the purpose of preserving the life of the mother.[34]

A liberal interpretation of 'preserving the life' was adopted in Bourne. It can thus be argued that 'life' should not be strictly construed. It ought to encompass the physical and mental health of the person. Where the physical or mental health of the person has deteriorated to such an extent that the person himself wishes to put an end to it, can the defence of necessity under section 81 of the Penal Code be utilised? The answer depends on whether the harm to be prevented e.g. pain and suffering is of such a nature and so imminent as to justify the risk of doing the act.[35]

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33 Ibid, at p 691.

34 Ibid, at p 694.

35 See Explanation, section 81 of Penal Code.

Confining the arguments to criminal law alone without resorting to the ethical principles and other factors such as the reality and practicality of euthanasia, sanctity of life is given the utmost priority.[36] Under the circumstances, unless the basic underlying emphasis on sanctity of life is amended euthanasia is not a justifiable act under the existing criminal law. The defence of necessity would fail.

(3) Provocation

There may be circumstances where provocation can be pleaded to mitigate a murder charge. This is stated in Exception 1 of section 300 of Penal Code:

> Culpable homicide is not murder if the offender, whilst deprived of the power of self control by grave and sudden provocation, causes the death of the person who gave the provocation, or causes the death of any other person by mistake or accident.

The exception above is however, qualified by the following provisoes:

> Firstly - That the provocation is not sought or voluntarily provoked by the offender as an excuse for killing or doing harm to any person.

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36 See Glanville Williams, The Sanctity of Life and Criminal Law, Alfred A Knopf, New York, 1970.

> Secondly - That the provocation is not given by anything done in obedience to the law, or by a public servant in the lawful exercise of the powers of such public servant.
>
> Thirdly - That the provocation is not given by anything done in the lawful exercise of the right of private defence.

Can a person infected with HIV who is charged under section 300 of Penal Code plead that he was provoked by the deceased? For instance, if he was openly taunted by being called a homosexual due to his infection or the fact that he is being ostracised. What if he was asked to leave the company where he worked due to his seropositivity? Although these may seem trivial, the circumstances leading to the situation would also have to be considered. The test is that of a 'reasonable person'.[37] The Supreme Court of India in Nanavati v State of Maharashtra[38] in construing Exception 1 of section 300 of the Indian Penal Code[39] ruled that '[w]hat a reasonable man will do in certain circumstances depends upon the customs, manners, way of life, traditional values, etc.; in short, the cultural, social and emotional background of the society, to which the accused belongs.'

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37 Holmes v Director of Public Prosecutor [1946] AC 588, HOL.

38 A.I.R. 1962 SC, 605, at pp. 629-630.

39 Exception 1, section 300 of Indian Penal Code is in pari materia with the equivalent provision in the Malaysian and Singapore Penal Codes.

The decision was followed in Vijayan v PP[40] where the Singapore Court of Criminal Appeal held that an 'ordinary reasonable man' was one who belonged 'to the same class of society as the accused.' As such, when assessing the effect of the provocative conduct on an accused person, the court must take into account the effect of such conduct on a reasonable person i.e. one who belongs to the same social, cultural and emotional background as the accused. That being the case, the fact that a person is HIV-positive would have to be taken into consideration by the court as it affects the social standing and emotional frame of mind of the accused.

Whether the court would go so far as to adapt the 'reasonable man' as being the reasonable man who is HIV-positive in Malaysia or even a particular ethnic group in Malaysia is yet to be seen. Keeping in mind the adverse social and cultural reaction towards those who are HIV-positive, it may perhaps be necessary for the courts to extend the reasonable man test to the specific group of those who are infected with HIV. The question would then be: would a reasonable man with HIV react to the provocative act in such a way as the accused person?

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40 [1975] 2 MLJ 8.

41 Ibid, at p 12.

(4) Conclusion

Perhaps terminal cases, AIDS in particular, ought to be distinguished from the traditional suicide cases where the circumstances and motive behind the taking of one's life are different. Suicide cases normally involve an emotionally or mentally distressed or depressed persons. The reason behind such emotional distress varies from trivial to serious. Euthanasia advocated here involves terminally ill patients who have no hope whatsoever at recovering with a very limited time left to his life. More importantly, these cases involve those who are in distressing pain and is suffering. It is acknowledged that not all AIDS sufferers are in distressing pain and suffering. In fact, most of them get infections which can be treated or managed i.e. symptomatic treatment. The category of 'terminally ill' must be clearly defined to avoid AIDS sufferers who are emotionally distressed and depressed from resorting to euthanasia. The distinction should be made because euthanasia, once recognised, can be regulated. Patients contemplating euthanasia must be in the classified category of terminally ill. These patients can be counselled prior to making their decision. It would therefore not be a rash decision as in the traditional suicide case.

Policy arguments upholding sanctity of life can be countered by the argument that in the defined or selected euthanasia cases the State has nothing to gain by forcing these

people to suffer till the end of their lives. These are cases where the decision has been carefully weighed and finally made taking into consideration the underlying rationale that a person should be given autonomy over his own person.

Quality of life should be considered instead of blindly upholding the sanctity of life. Public interest cannot possibly be threatened by euthanasia. It basically is a personal choice. In fact, public interest may be served by the minimisation of suffering (of the patients themselves and also that of their relatives').

With the ever increasing number of AIDS cases, the hospitals would be getting more and more AIDS patients. It is only logical and practical that AIDS cases which have reached the terminal stage be given the option of euthanasia. It is pertinent to note that euthanasia, in its various forms, is practised in Malaysia and will continue to exist. Many a times the doctor is faced with a patient who requests to be discharged from hospital so that he can 'die in peace' at home. In such cases, the patient will be discharged 'at his own risk'. This situation can be classified as euthanasia though cloaked in a different form. Although the patient is technically discharged, it is actually a rejection of further treatment by the patient himself.

It would seem generally ridiculous and legally serving no objectives or aims of the criminal law in such an instance to prosecute that patient for attempted suicide or the doctor for abetting suicide. In practical terms, the prosecution always have the discretion not to prosecute such cases.[42] It is therefore urged that this category of cases should properly be among those for which there should be no prosecution in principle.

It is submitted that euthanasia in AIDS cases should be allowed on humanitarian grounds i.e. compassion and the principle of autonomy. Criminalisation of such cases does not make sense as the circumstances surrounding it makes it stand in a class of its own. There is also the tendency of being sympathetic and lenient to doctors who have been so charged.

What public interest is served by dragging the doctors to court and subsequently letting him off with either a light sentence as is in the case of Dr. Nigel Cox or even an acquittal?

The peculiarity of the circumstances surrounding euthanasia was also recognised in the well publicised American case of Karen Ann Quinlan.[43] The Supreme Court held that the

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42 Art 145(3) of Federal Constitution,
Section 254 Criminal Procedure Code FMS Cap 6.

43 70 NJ 10, 355 A. 2d, 647.

father of the patient should be the guardian and concluded that Karen's right of privacy may be asserted on her behalf. Criminal and civil liability for removing the life support system was eliminated by the court. The patient who was 21 years old then, went into a deep coma from undetermined causes. When it became clear that she could never regain consciousness, her parents decided to remove the artificial life support system. The issue before the court was - who had the legal right to remove or allow the removal of the respirator connected to the patient?

Although the case was based on the right of privacy, the impact of the decision on criminal and civil liability for such actions is to be taken note of.

It is submitted that it is perhaps more reasonable to accept and accord recognition to euthanasia rather than allow the mockery of criminal law. As it is there has been no prosecution of doctors for the offences discussed in this chapter in the situation of euthanasia. Several factors may account for this - the fact that there is no complainant, difficulty of detecting such cases and also the fact that doctors are still regarded by many as knowing what is best for the patient.

In the meantime, a solution that may be useful to doctors attending to those who are terminally ill or will be so such as in cases of AIDS is to consult the patient prior to the stage when they cannot communicate any longer. If such consultation are held between the doctor and patient, the patient may be better informed of the whole situation and may under the circumstances, express his wish of not to be resuscitated or be given a life support system. This is taking into consideration that AIDS patients may require costly and extraordinary measures to maintain their quality of life. By respecting the wish of the patient in such a situation, one allows him to participate in a fundamental decision regarding himself and allow him to die with dignity.

E. Sentencing

(1) 'Reasonable Excuse'

Besides the offences discussed above, there are other consequences of HIV infection and AIDS on the wide spectrum of criminal law. Can the fear of being infected with HIV or contracting AIDS justify certain actions or omissions? In Fountain v DPP[44], the accused was charged under section 8(7) of the Road Traffic Act 1972 for failing to provide a specimen for a laboratory test, without reasonable excuse. The accused was

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44 [1988] Crim. LR 123.

seen swerving his car and was asked by the police officers for a specimen of his breath. He was unable to inflate the bag and was arrested. The intoximeter could not be used because he had only one lung. He was then asked for two specimens of his blood, to which he replied: 'in view of the danger of AIDS, I would rather not give blood.' The magistrate dismissed the charge and held that in the absence of any attempt by the police to allay his fears, his stated fear of AIDS was a reasonable excuse.

This finding was however, upon appeal by the Crown, reversed and the magistrate was directed to convict. It was held that no belief on the part of the accused could afford a reasonable excuse, which could only arise if he were mentally or physically unable to provide the specimen or if to do so would entail a substantial risk to his health. The scope of 'reasonable excuse' was thus clarified. It was further held that there was no statutory duty on the police to explain the procedure for taking a blood sample, so as to allay fears of AIDS. Under the circumstances, the court seem to have taken the stand that fear alone would not amount to 'reasonable excuse'. It is only when it entails a substantial risk to his health that the accused would be justified to have such fear, thereby having reasonable excuse for so refusing.

Thus if the accused believes correctly that his health would be seriously at risk, he is not guilty. If he believes genuinely but incorrectly that his health would be at risk, then on general principles he has a good case for acquittal too though such mistaken belief may have to be based on reasonable grounds to amount to 'reasonable excuse'. In the case above, where the accused did not know the true facts and nobody seeks to enlighten him, can it be said that his bona fide belief, though mistaken, was reasonable?

Would the relevant officer be liable for assault if he ignores the offender's refusal to give blood? If the above case has arisen locally i.e. taking of blood specimens for tests vis-a-vis a criminal proceeding, the action of the officer concerned may be protected by law. Under section 76 of Penal Code[45], an act by a person who is or who by reason of a mistake of fact in good faith believes himself to be bound by law to do it would not amount to an offence.

Similarly section 79[46] states:

> Nothing is an offence which is done by any person who is justified by law, or who by reason of a mistake of fact and not by reason of a mistake of law in good faith believes himself to be justified by law in doing it.

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45 FMS Cap 45.

46 Ibid.

(2)(a) Sentencing - AIDS as an aggravating factor

Another aspect that should be explored is the effect of HIV/AIDS on sentencing. There are several possible facets to this area. Firstly, should the fear of HIV infection and AIDS on the part of the victim be an aggravating factor in the consideration for the sentence? This question may arise in cases of offences against the person, especially that of rape. It is essential to consider this possibility as it is a fact that one of the modes of HIV transmission is via sexual intercourse. The risk of such a transmission increases with the greater possibility of injury due to a forced sexual intercourse in a rape case. Should such risk of transmission to the victim be an aggravating factor in sentencing the offender?

The more established aggravating factors include the previous convictions of the offender, the prevalence of such offences, the use of violence in the commission of the offence and the grave or serious circumstances of the offence. Where the offence was committed in a callous, calculated and brutal manner as in Safian bin Abdullah[47], the Court gave due regard to the deterrent aim of the sentence. Similarly in Joginder

47 [1983] 1 CLJ 324.

Singh v PP[48], the grave nature of the offence was taken into account by the Court as one of the aggravating factors for sentencing.

The guidelines in Billam[49] laid down a number of aggravating features to be taken into consideration by the court in sentencing. These include the use of additional violence, use of a weapon, repetition of the rape and the effect on the victim, be it physical or mental.

Can the grave or serious circumstances of the offence include the risk of HIV transmission to the victim? Would the fear of the victim in contracting AIDS be considered by the Court as an aggravating factor to the sentence? Or need there be actual transmission or actual proof that the offender was HIV infected? There is no reported local case dealing with this particular point.

This issue was however referred to in R v Malcolm.[50] The accused had pleaded guilty to false imprisonment and rape. He attacked two girls who were trying to find a minicab in the early hours of the morning. He

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48 [1984] 2 MLJ 133.

49 (1986) 8 Cr. App. R. (S) 48.

50 [1988] Crim. LR 189.

threatened both of them with a knife and dragged one of them to his flat, holding a knife to her throat. He then forced her to participate in oral sex and raped her twice. He had various previous convictions, including one for indecent assault on a male. He was sentenced to 12 years' imprisonment for rape with five years concurrent for false imprisonment. The appellant appealed against the sentence.

It was argued that the sentence allowed no credit for the appellant's plea. The sentencer had referred to growing public awareness of the risk of a rape victim contracting AIDS and observed that the law could only recognise this fear by imposing a far heavier sentence than in the past. The Court of Appeal commented that the question whether fear of AIDS justified a higher tariff might have to be considered by the Court in the future but if there was a case in which evidence of the conditions of the victim was put before the court, as it should be, and it was shown that there was some valid reason for her fearing having contracted AIDS or that her blood did in fact contain the HIV, that was a factor which justified a sentence over and above that suggested by the Billam guidelines.

It was held that in the absence of such evidence, the sentencer was not justified in adding to the sentence an element for the AIDS factor. The Court accordingly reduced the sentence to ten years, ignoring the AIDS factor and discounting

two years for the plea. An offender who pleads guilty spares the victim the indignity and trauma of having to give evidence and relive the experience.

It is not impossible in the near future to have cases where evidence of the condition of the victim and the reasonable fear of being infected by HIV and/or contracting AIDS are forwarded as factors to be considered in imposing a sentence. The very fact that the infection is lifelong and there being no cure for AIDS at the current moment will only serve to further strengthen the argument for including it as an aggravating factor in sentencing. Should the offender know of his HIV status[51] or would it suffice to show that the victim had valid reasons to fear such an infection? Should the fear be reasonable i.e. should it be coupled by the fact that the offender is infected with HIV or would it suffice if there is a reasonable belief that he is so infected?

On the other hand, should there be fear of being infected on the part of the victim at all? This is especially pertinent where despite being aware of his seropositivity the

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51 In a recent rape case the accused surprised the court when he pleaded for leniency on the grounds that he is suffering from AIDS. He admitted that he was aware of it before committing the offence. He was sentenced to five years' imprisonment and ordered to be given three whips - reported in The Star, February 8, 1993, at p 4.

offender committed the rape.[52] Should such sheer disregard of the risk of infecting the victim be an aggravating factor to the sentence?[53]

The Court in the case above recognises that if it is shown that the victim was put in fear of contracting AIDS as a result of rape or did in fact contract the virus, it is a factor which should enter in the calculation of sentence. It is significant that the Court indicates that evidence of the condition of the victim should be placed before the sentencing court. One can presume that this would include the AIDS factor, venereal disease, pregnancy or mental symptoms. Is the Court being too simplistic in assuming that evidence can be brought to prove transmission of HIV? It is a fact that scientifically, the actual moment of transmission cannot be conclusively stated due to the incubation period. It may take years before HIV antibody is detected. It is also difficult to identify the source of transmission. Today it is done mainly by deductions i.e. taking into account the background and lifestyle of that person. The personal history of the person has to be scrutinised to narrow down the various possible sources of transmission. This would add to the trauma a

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52 Ibid.

53 Such an act would amount to an offence under section 12(2), Prevention and Control of Infectious Diseases Act, 1988 and sections 269 and 270 of Penal Code. Supra. Chapter IV, Part C.

complainant or victim in a rape case has to endure. In addition to the trial proper, she has to again endure the embarassment and indignity of having her personal life scrutinised. Although such evidence can be part of the prosecution's case, it is not clear who has the responsibility for placing such evidence before the court where it does not form part of the prosecution's case.

It is therefore not an easy task to include the fear of HIV transmission or AIDS as an aggravating factor in sentencing. The questions posed above need to be resolved first before such a factor can be accepted as an aggravating factor. It is also noted that there is no statutory basis for aggravating factor to be considered by the court prior to sentencing unlike mitigating factors where section 173A and section 294 of the Criminal Procedure Code[54] can be referred to.[55]

(2)(b) Sentencing - AIDS as a mitigating factor

The earlier paragraphs pertain to the relevance of the fear of AIDS in certain criminal cases. Another aspect of sentencing can also be affected by AIDS. Can an offender's

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54 FMS Cap 6.

55 Infra p 214.

ill-health be a factor to mitigate the sentence imposed? This general question applies to the various numerous offences under the criminal law.

The relevant provisions to be considered here are sections 173A and 294 of the Criminal Procedure Code.[56] These provisions mention health of the offender as one of the matters to be considered by the Court when deciding whether to release the offender on a bond of good behaviour.

Section 173A Power to discharge conditionally or unconditionally

> (ii) When any person is charged before the Court with an offence punishable by such Court, and the Court finds that the charge is proved, but is of the opinion that, having regard to the character, antecedents, age, health or mental condition of the person charged[57], or to the trivial nature of the offence, or to the extenuating circumstances under which the offence was committed, it is inexpedient to inflict any punishment or any other than a nominal punishment or that it is expedient to release the offender on probation, the Court may, without proceeding to record a conviction, make an order either -
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> (a) dismissing the charge or complaint after such admonition or caution to the offender as to the Court seems fit; or

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56 FMC Cap 6.

57 Emphasis is mine.

(b) discharging the offender conditionally on his entering into a bond with or without sureties, to be of good behaviour and to appear for the conviction to be recorded and for sentence when called upon at any time during such period, not exceeding three years, as may be specified in the order.

Similar considerations are to be given under section 294:

Section 294 First offenders

(i) When any person not being a youthful offender has been convicted of any offence punishable with imprisonment before any Court if it appears to such Court that regard being had to the ... health or mental condition of the offender ... it is expedient that the offender be released on probation of good conduct, the Court may, instead of sentencing him at once to any punishment, direct that he be released on his entering into a bond with or without sureties ... to keep the peace and be of good behaviour.

There is no doubt that the health and mental condition of the offender are factors to be considered by the Court prior to sentencing. In a recent case[58], the accused pleaded for leniency in a rape case on the grounds that he is suffering

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58 Supra footnote 51 at p 211.

from AIDS. He claimed he was certified as a HIV carrier but had lost the medical document. He was sentenced to five years' imprisonment and ordered to be given three whips. It is not certain whether the Sessions Court judge[59] took it as being a factor affecting the health of the accused. Drug dependence cases have however, been considered by the Court.

In Mohamed bin Abdul Rahman v Pendakwa Raya[60], the appellant was charged for possession of dangerous drugs under section 12(3) of the Dangerous Drugs Ordinance, 1952. At the trial he was convicted and sentenced to six months' imprisonment. On appeal, the Court took into consideration that the appellant is young and a first offender. Noting the fact that he was an addict and not a pusher, the sentence of imprisonment was set aside and a fine of $400 was imposed in its place.

It is clear however that if the offences committed were serious ones, the Court would be less likely to consider the various mitigating factors, the health of the offender included. In PP v Haled[61] the offender was a drug addict. This was not given much weight by the Court due to the violent manner in which he committed the offence of attempted robbery.

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59 Judge Teo Say Eng.

60 [1969] 1 MLJ 252.

61 [1981] 2 MLJ 211.

He had used a fairly heavy hammer to strike at the complainant's head. Further illustration can be drawn from an Australian case.

In R v Smith[62], a South Australian case, the appellant was sentenced in the Supreme Court on two charges of breaking, entering and larceny and one of arson. He pleaded guilty to the breaking charges and was found guilty by a jury on the charge of arson. The sentences imposed were twelve months on the first charge of breaking, entering and larceny, fifteen months on the second such charge and four years for arson, to be served concurrently. An appeal against the sentences was made.

Pending determination of the appeal, the appellant was diagnosed as having antibodies of the HIV. Information as to his medical condition was before the learned sentencing judge on hearing of the application for leave to appeal and for bail. Counsel sought to have the evidence admitted on appeal. The Court asserted that the proper purpose of fresh evidence on appeal against sentence is to bring before the court facts which were in existence at the time of the imposition of the sentence but were not known to the sentencing judge or to

62 (1987) 44 SASR 587.

explain facts which were before the judge so as to put them in a new light. It is not open to the Court to intervene upon the basis of events which have occurred since the imposition of the sentence.[63] The Court however distinguished the present case by looking at the purpose of admitting such evidence even though it occurred after the passing of the sentence.

The Court was of the opinion that it was for the purpose of explaining the full extent and implications of the appellant's condition of health which existed at the time of sentence; showing the true significance of facts which were in existence then.

The Court admitted the fresh evidence as the events occurring since sentence are admissible to show the extent and implications of the condition of health of the appellant. In the light of the circumstances of the case and the fresh evidence as to the appellant's condition, the Court felt it necessary to reconsider the sentence imposed. The non-parole period was reduced from three years to nine months.

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63 R v O' Shea (1982) 31 SASR 129. In Rajendra Prasad v PP [1991] 1 MLJ 1, the Singapore Court of Criminal Appeal laid down the tests for additional evidence on appeal. Before the discretion can be exercised, it must first be shown that the evidence could not have been obtained with reasonable diligence for use at the trial, the evidence must have an important influence on the result of the case and the evidence must be apparently credible.

In considering how far new information about the appellant's health i.e. being HIV antibody positive, affect the sentence, King CJ stated:[64]

> The state of health of an offender is always relevant to the consideration of the appropriate sentence for the offender. The courts, however, must be cautious as to the influence which they allow this factor to have upon sentencing process. Ill health cannot be allowed to become a licence to commit crime, nor can offenders generally expect to escape punishment because of the condition of their health.

The learned judge further explained that generally speaking, ill health will be a mitigating factor to the sentence only when it appears that imprisonment will be a greater burden on the offender by reason of his state of health or when there is a serious risk of imprisonment having a gravely adverse effect on the offender's health. In the present case, the evidence shows that there is a substantial risk that the stress associated with a further period of imprisonment will cause some deterioration in the condition which afflicts the offender.

It is submitted that the above rationale and consideration regarding offenders who are tested HIV antibody positive after being sentenced are cogent and applicable in the

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64 (1987) 44 SASR 587, at p. 589.

Malaysian context. It might however, be limited to those cases where evidence can be tendered in court to show that a prolonged period of imprisonment would be detrimental to the health of the offender. As cautioned by the learned judge, it should not be used as a licence to escape punishment.

The practical aspect of taking this stand however, is undeniable. At present, prisoners who are identified as HIV antibody positive are isolated from other prisoners. This may be due to the fact that homosexual activities cannot be effectively curbed in prisons.[65] As a measure against the transmission of HIV via such activities, the prison authorities have resorted to placing such prisoners in selected prisons.

In the advent of HIV infection and AIDS amongst prison inmates, there is a need to rethink the whole process of sentencing, its aims and purpose and the practical problems that exist. Factors such as overcrowding due to lack of facilities, lack of trained personnel to deal with such inmates and the long-term costs of health care of these inmates need to be taken into consideration besides the traditional aim of punishing the offender.[66] The correctional aspect need to be

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65 The News Straits Times, 10th December 1992, 'All is not well at rehab centres', pp 25 and 33.

66 See Molly Cheang, "Non-Custodial and Semi-Custodial Sentences (Alternatives to Imprisonment)", a paper presented at INTAN on 3-4th March 1992.

emphasised to bring it in line with the National Plan of Action for the Prevention and Control of AIDS. Such inmates need to be counselled and educated on the basic facts of HIV transmission and AIDS so as to enable them to actively contribute to the prevention of HIV transmission via a changed behaviour.

The humanitarian aspect must also be respected. Those with HIV and AIDS sufferers must be treated as any other inmates with diseases such as Hepatitis B. It is acknowledged however, that under the present circumstances, the prison authorities have no choice but to isolate and put all these prisoners in two identified prisons - Kajang and Johor Baru.[67] This is due to various factors including the fact that it is easier to monitor and manage the identified prisoners. It has been admitted that there are still many difficulties to overcome such as the classification of prisoners whether on remand, out on bail or awaiting sentence and the tracing and monitoring of such cases. Nevertheless, it is beyond the scope of this thesis to explore this particular area which ultimately is more of an administrative matter at this stage.

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67 The Star, 1st December 1992.

CHAPTER VI

ANCILLARY LEGAL ISSUES

There are several other legal issues that need to be addressed. These include the right to refuse treatment which can be linked to euthanasia and the refusal to treat. In this chapter, possible solutions to the issue of euthanasia are discussed. Ethical considerations and legal implications of refusal to treat are also looked at.

A. Right to Refuse Treatment

At present, euthanasia constitute several offences under the Malaysian criminal law from abetment to suicide to murder as discussed in Chapter V. If looked at from another perspective, euthanasia may be condoned. It is undeniable that a patient has the right to refuse treatment. In fact, where the patient has specifically refused to undergo treatment, the doctor has no choice but to accept that decision. This however, does not extend to doctors assisting the patient to die such as the case of assisted suicide.

The situation that arise in euthanasia is where death results even though by resorting to proper remedies and skilful treatment, the death might have been postponed.[1] Would the omission to treat by the doctor, prompted by the refusal of treatment by the patient amount to culpable homicide under section 299 of the Penal Code?

Section 299 Culpable homicide

> Whoever causes death by doing an act with the intention of causing death, or with the intention of causing such bodily injury as is likely to cause death, or with the knowledge that he is likely by such act to cause death, commits the offence of culpable homicide.

The word 'act' in section 299 extends to illegal omission. This is stated in section 32 of the Penal Code:

Section 32 Words referring to acts include illegal omissions. In every part of this Code, except where a contrary intention appears from the context, words which refer to acts done extend also to illegal omissions.

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1 Explanation 2 of Section 299, Penal Code. See infra p 4.

The term 'illegal' is defined under section 43 of Penal Code:

Section 43 The word 'illegal' is applicable to every thing which is an offence, or which is prohibited by law, or which furnishes ground for a civil action ...

Whether or not the omission to treat in this instance constitute an 'act' under section 299 would depend on whether it is an illegal omission. An omission is illegal only when there is a duty to treat. Here, where the patient has refused to be further treated, it is submitted that there no longer exists a duty to treat. Therefore it may be argued that such an omission would not be caught under section 299. It has been held that doctors must respect the patient's wish in not accepting blood transfusion even when they know the patient will die as a consequence of that refusal.[2] This stand seems to be in conflict with section 299 of the Penal Code.

Explanation 1 A person who causes bodily injury to another who is labouring under a disorder, disease, or bodily infirmity, and thereby accelerates the death of that other, shall be deemed to have caused his death.

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2 R v Blaue [1975] 1 WLR 1411.

Explanation 1 of section 299 is quite clear on this point. A possible contention against its application is the term 'causes bodily injury'. In the context of omission to treat, what bodily injury has been caused? It can be argued that no bodily injury was inflicted and that the death was caused by the underlying disease, not by the omission to treat.

Similarly, under Explanation 2, such an argument can be forwarded.

> Explanation 2 Where death is caused by bodily injury, the person who causes such bodily injury shall be deemed to have caused the death, although by resorting to proper remedies and skilful treatment the death might have been prevented.

This Explanation may also cover euthanasia i.e. where death might have been prevented if proper remedies or skilful treatment had been rendered. Thus, if both the arguments above regarding omission to treat not being an 'act' and 'bodily injury' are rejected, a doctor who omits to treat, although respecting the patient's wish, may still be liable under section 299 i.e. culpable homicide.

This puts the doctor in a quandry. Although it is not denied that the patient has a right to refuse treatment, the law does not recognise the doctor's respect of the patient's wish as a defence or justification under section 299 of the Penal Code. Theoretically, it seems that a dying patient has the right to refuse further treatment. However, it is up to the doctor whether or not to respect that right. The doctor is at present in the unenviable position of being caught either way. He is expected to respect the patient's wish but such an action brings with it the possibility of being prosecuted under section 299.

It is standard practice today for the doctor to obtain a signed declaration from the patient who refuse treatment, stating that they are refusing treatment 'at their own risk'. Although in effect it uses a contractual term to oust possible criminal liability, it is submitted that this would suffice to absolve the doctor from the duty to treat. This would be in furtherance to the earlier argument that when there is no duty to treat, it cannot be said that the omission to treat amounts to an illegal omission.

In England, a proposal was made by the Criminal Law Revision Committee for an offence of mercy-killing punishable with two years' imprisonment.[3] This was to bring it in line

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3 CLRC's 1976 Working Paper on Offences Against the Person.

with reality where the outcome in prosecuting such cases invariably is a virtual let-off due to the benevolent attitude of the prosecution, the judge, members of the medical profession and very possibly, even the jury. The grave charges of murder, culpable homicide not amounting to murder, attempt to murder, attempt to culpable homicide and abetment to suicide were recognised to be wholly inapt under the circumstances. Unfortunately, the proposed offence met with immense opposition from Christian bodies and societies which staunchly upheld the principle of the sanctity of life. The proposal was dropped and was not even mentioned in the Committee's final Report.[4]

English cases seem to be more conservative as they tend to confine themselves to the offences charged. There are several American cases that would be of assistance in the context of this discussion. Although many of the American cases raise constitutional issues such as right of privacy, it is noteworthy that common law is also often developed in such cases.

In situations where the patient has reached terminal stage and there is no longer any treatment which will cure or prevent the progress to death and where the patient who is sustained by life-support system, a better view would be they

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4 Glanville Williams, "The Right to Die", New Law Journal, Jan 27, 1984, 73 at p. 76; CLRC's fourteenth report (1980) on Offences Against the Person (para 115).

do not commit suicide when they refuse treatment or ask for the life support system to be terminated.[5] The United States President's Commission Report 'Deciding to Forego Life-Sustaining Treatment' in 1983 explained:[6]

> ...[I]n recent years judges have consistently distinguished between suicide and the refusal of treatment by, or on behalf of, terminally ill patient ... in cases in which treatment refusal has been found to be acceptable, courts have held that death resulted from a 'natural cause' - the patient's illness - which means that the patient's death was not considered to result from suicide, since it was neither self-inflicted nor 'caused' by health professionals who honored the patient's decision to refuse treatment. The Commission has not found any instances in which criminal or civil liability has been imposed upon health professionals or others (such as family members) for acquiescing in a patient's refusal of life-sustaining treatment.

This view is reaffirmed in Re Conroy[7] by Mr. Justice Shrieber:

> ... In any event, declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical treatment merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury.

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5 Refer to earlier discussion on 'Suicide' at p 176-181 in Chapter V.

6 At p. 38-39.

7 486 A 2d 1209 (1985) at 1224.

In Re Conroy[8], the facts pertain to an incompetent patient but the court analysed the legal issues in the case of a competent patient. At the time of trial, Ms Conroy was no longer ambulatory and was confined to bed, unable to move from a semi-fetal position. She suffered from arteriosclerotic heart disease, hypertension, and diabetes mellitus. Her left leg was gangrenous to her knee. She had several decubitus ulcers (bed sores) on her left foot, leg and hip; an eye problem required irrigation. She had a urinary catheter in place and could not control her bowels. She could not speak and her ability to swallow was very limited.

On the other hand, she interacted with her environment in some limited ways: she could move her head, neck, hands and arms to a minor extent. She was able to scratch herself and had pulled at her bandages, tubes and catheter. She moaned occassionally when moved or fed through the tube or when her bandages were changed. Her eyes followed individuals in the room; her facial expressions were different when awake compared to her sleeping state and she smiled on occasion when her hair was combed or when she received a comforting rub.

Although she was not brain dead, comatose or in a chronic vegetative state, her intellectual capacity was very limited and her mental condition would probably never improve.

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8 Ibid (New Jersey Supreme Court).

The court concluded that Ms Conroy, if competent to make the decision could have chosen to have her nasogastric tube withdrawn. Her interest in freedom from nonconsensual invasion of her bodily integrity was held to outweigh any state interest to preserve life or to safeguard the integrity of the medical profession.

In addition, such patients may not harbour a specific intent to die; rather, they may indeed wish to live, but to do so free of unwanted medical technology, surgery or drugs and without protracted suffering.[9] It can therefore be concluded that recognising the right of a terminally ill person to reject medical treatment respects that person's intent, not to die, but to suspend medical intervention at a point consonant with that individual's view of a personally preferred manner of concluding life. The difference is between self-infliction or self-destruction and self-determination.

B. Evaluation of right to refuse treatment

The right of a person to control his own body, based on the principle of autonomy, is a basic societal concept long recognised in the common law. It is submitted that the right to refuse medical treatment is embraced within the common-law

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9 Satz v Perlmutter 362 So 2d 160 (1978), affd 379 So 2d 359 (1980).

right to self-determination.[10] Therefore, a person of adult years and of sound mind i.e. competent, has the right to determine whether or not to submit to lawful medical treatment, even that which may prolong his life.[11] The American position is referred to here because it is mainly in the United States that the relevant issues have been litigated upon. English case law and local law seem to be trailing behind in this area.

In Bouvia[12], the court upheld Elizabeth Bouvia's right to refuse medical intervention. The prospect for a prolonged existence if her application was rejected was described by the court as being an ordeal which is inconceivable for the State to inflict upon anyone. Here, if forcefed, the applicant faces 15 to 20 years of painful existence, endurable only by the constant administrations of morphine. Her condition is irreversible, there being no cure for her palsy or arthritis. She would have to be fed, cleaned, turned, bedded and toileted by others for 15 to 20 years. The court commented:

> We do not believe it is the policy of this State that all and every life must be preserved against the will of the sufferer.

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10 In the American system, the right to refuse treatment is based on the constitutional right of privacy. See In re Quinlan, supra at p. 203, footnote 43.

11 Bouvia v Superior Court (1986) 225 Cal Rptr 297.

12 Ibid

This case makes it clear that a competent patient may refuse life-sustaining treatment even though she is not dying. However, the doctor still has a duty to comfort her by providing appropriate treatment for symptomatic relief unless this is also refused.

The United States President's Commission had earlier identified the principle stated in Bouvia as being the law in its 1983 Report:[13]

> The voluntary choice of a competent and informed patient should determine whether or not life-sustaining therapy will be undertaken, just as such choices provide the basis for other decisions about medical treatment. Health care institutions and professionals should try to enhance patients' abilities to make decisions on their own behalf and to promote understanding of the available treatment options.
>
> ... Health care professionals serve patients best by maintaining a presumption in favour of sustaining life, while recognising that competent patients are entitled to choose to forego any treatments, including those that sustain life.

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13 At p. 3.

The American position regarding the right to refuse treatment, even life-sustaining treatment as stated in Bouvia[14] is the same as that of English law as illustrated in R v Blaue[15] where a Jehovah's Witness refused to consent to a blood transfusion even though she knew she would die without one. There was no hint of criticism of the doctor who respected her wishes. Blaue was the original assailant, who was indicted for murder. Had there been grounds for criticising the doctor's omission to act, Blaue's counsel could have suggested that the doctor's conduct contributed to a break in the chain of causation between Blaue's acts and the girl's death.

It is submitted that AIDS patients have the right to refuse life-sustaining treatment. This right can be exercised by the patient either prior to reaching the stage where such treatment need to be resorted to or at that terminal stage itself. There ought to be no criminal or civil liability against the health care team and the hospital in such cases.

There are competing policy arguments in respect of the right to refuse treatment. The principle of sanctity of life if taken to the extreme would not recognise such a right if it

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14 See also Bartling v Superior Court 309 Cal Rptr 220 (1984).

15 [1975] 3 All ER 466, [1975] 1 WLR 1411.

affects or 'endangers' a life. As such it only acknowledges the right to refuse treatment if it does not in any way threaten the said life. The State's interest in upholding this principle is reflected in the criminal law under offences against the person.[16] It can then be argued that it would be against public policy to condone the right to refuse treatment in such instances as they amount to suicide or even murder. It is submitted however that the right to refuse treatment by terminally ill patients be distinguished from the traditional suicide case.

Contrary to self-destruction in a suicide, such a case is actually an assertion of the principle of autonomy i.e. the right to decide for oneself regarding one's body. Besides this, the economic burden that would be placed on the patient and his family would lend some practical argument for supporting the principle of autonomy. What possible benefits can the State derive from insisting that such a life be prolonged at the expense of the patient and his family - physically, mentally and economically?

To overcome the present dilemma where a doctor and the health care team are not protected under the law in cases where the patient had refused life-sustaining treatment, statutory

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16 Supra Chapter IV, Part C(4) and Chapter V, Part A-C.

intervention may be resorted to. The various possible situations that may be faced by the doctor and the health care team in their contact with AIDS patients and the corresponding criminal sanctions have been mentioned earlier. These include the terminating of life-support system, administration of drugs to reduce pain and suffering and also providing access to drugs or equipments enabling the patient to end their own lives.

There are three possible solutions regarding these cases. All three requires the active participation and commitment of the Attorney-General's Chambers and the Legislature. These are:

(i) legalization of euthanasia

(ii) descriminalization of compassionate murder and suicide.

(iii) the enactment of a Natural Death Act and recognition of living wills.

(1) Legalization of euthanasia

This requires an acceptance of euthanasia. Recognition of the necessity of euthanasia in certain cases would be a necessary prelude to the introduction of a bill on this

matter. Once that is achieved, there is a need to impose state supervision and control by introducing procedures for judicial safeguards against abuse. An Euthanasia Act can be enacted incorporating the various aspects of the matter.

Firstly, the persons who can be given the choice of euthanasia should be clearly defined and identified. This should include persons with painful and terminal disease who have at best a specified period to live (the time period can be decided upon). This would include AIDS sufferers in the terminal stage.[17]

A procedure for determining the applicability of the proposed Act to a particular case should be established. A certification process by two physicians of the 'terminal' status could constitute the basis. A signed and witnessed declaration can be made by the patient after prior consultation with the attending doctor and possibly a psychiatrist specialising in this area. A consultation with the respective

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17 The other groups who may need to be included are those who are incapable consent. These include degenerate persons, the mentally ill and those with gross physical defects who are being kept alive via the life-support system. Comatose patients would also fall into this category. Although a venture into the discussion in this area would prove to be exciting, it is unfortunately not within the scope of this thesis.

religious authorities should also be made available if requested. This declaration should be included in the patient's medical record. A committee can be set up in the hospital to authorise euthanasia. The duties and obligations of the health care team should be clearly laid down. Those who conscientiously object to such a procedure may arrange to transfer the case to another doctor who is willing to carry it out.

The administration of drugs to relieve pain and suffering should be clearly stated as permissible and not constitute an offence.

Acts permitted under the statute and performed in good faith for the benefit of the patient should be exempt from liability - be it civil or criminal. Other factors such as that of insurance policy can also be included. It can be specified that a death that occurs subsequent to the administration of euthanasia shall not be deemed to be a suicide or self-induced death.

The legalization of euthanasia would therefore permit the withholding or withdrawal of a life-sustaining procedure and the administration of drugs to relieve pain and suffering to such patient even though it may hasten death.

(2) Decriminalization of compassionate murder and suicide

This would involve amendments to the existing provisions in the Penal Code, taking into consideration the element of motive. This can be achieved by including motive as a substantive element of the stated offence or at least as a mitigating factor. The Swiss Penal Code of 1937 is an example where motive is a substantive element in deciding whether an offence has been committed. The essential element of murder is the reprehensible attitude or dangerousness of the person. The relevant provisions are as stated below:

> Article 111: 'manslaughter'
>
> Whoever intentionally kills a human being shall, in the absence of circumstances set forth in the following article, be punished by confinement in a penitentiary for not less than 5 years.
>
> Article 112 : murder
>
> Where the actor killed under circumstances or with a premeditation which show that he possesses a particularly reprehensible attitude or that he is dangerous, he shall be punished by confinement in a penitentiary for life.

Motive is also considered as a mitigating factor in reducing the penalty:

> Article 633:
>
> The judge shall mete out punishment in accordance with the guilt of the actor; he shall consider the motives, the prior life and the personal circumstances of the guilty person.

Article 64:

> The judge may mitigate the punishment ... where the actor was induced to commit the act by honourable motives ...

The element of honourable motives such as compassion can perhaps be included as a mitigating factor, if not a total exclusion from liability.

The term 'suicide' can be definitively stated so as to clearly exclude voluntary passive euthanasia. If this is done, it would absolve the criminal liability of doctors participating in voluntary passive euthanasia. One can distinguish such cases from actual suicide cases where the person concerned is physically healthy but mentally distraught and the self-destruction is irrational. The quality of life of the person in the near future must be considered. Where a person is suffering from a terminal disease and is in distressing pain, what possible benefits can the state gain by insisting that 'treatment' be continued when it would only prolong the process of dying?

(3) Enactment of a Natural Death Act and recognition of living wills

This would be in line with the development of advance directives of patients in the United States. Such advance

directives or living wills[18] as they are more popularly known reaffirm the principle of autonomy to the extent that the patient himself can decide to refuse life-sustaining procedures. It must be voluntarily executed i.e. with consent. To qualify, a patient must be diagnosed and certified in writing to be afflicted with a terminal conditions by two physicians, one of whom being the attending physician.

Safeguards can be included by requiring the presence of two witnesses who are not related by blood or marriage to the declarant and who would not be entitled to any portion of the estate of the declarant upon his death. The attending physician, other health care workers in the hospital and those who has a claim against the estate of the declarant upon his death should be excluded as witnesses. Another safeguard is the revocation methods of a directive. Such a directive may be revoked at any time by any of the stated methods including being torn or otherwise destroyed by the declarant and even a verbal revocation.

Such an Act would be limited to terminally ill patients who had given such a directive so as to permit the health care team to withhold or withdraw life-sustaining procedures. It would merely allow the natural process of dying

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18 A sample of a living will is in Appendix 12.

as provided and does not include the affirmative or deliberate act or omission to end life. It recognises the fundamental right of a person to control the decisions relating to his own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition. An AIDS sufferer in the terminal stage would fit into this category. It is however limited to a competent person at the time the declaration or directive is made.

The first living will statute in United States was the California Natural Death Act 1976. As at 1989, there are 36 living will statutes in the United States.[19] Such statutes basically accord recognition of means of refusing in advance futile prolongation of dying to those terminally ill with no hope of recovery. It also provides the health care team immunity from liability for carrying out patients' wishes under the circumstances specified in their living wills.

The Legislative findings and declarations of the California Natural Death Act 1976 are noteworthy.

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19 Kennedy and Grubb, Medical Law, Text and Materials, Butterworths, London, 1989, at p 1135.

7186. Legislative findings and declarations

The Legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition.

The Legislature further finds that modern medical technology has made possible the artificial prolongation of human life beyond natural limits.

The Legislature further finds that, in the interest of protecting individual autonomy, such prolongation of life for persons with a terminal condition may cause loss of patient dignity and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient.

The Legislature further finds that there exists considerable uncertainty in the medical and legal professions as to the legality of terminating the use or application of life-sustaining procedures where the patient has voluntarily and in sound mind evidenced a desire that such procedures be withheld or withdrawn.

In recognition of the dignity and privacy which patients have a right to expect, the Legislature hereby declares that the laws of the State of California shall recognise the right of an adult person to make a written directive instructing his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition.

C. Refusal to treat

(1) Ethical considerations

There may arise situations where the doctor, nurse or other health care workers refuse to treat or care for a

patient infected with HIV or suspected to be so infected. Indeed, this was the situation at the initial stage when HIV and AIDS were first discovered in Malaysia.[20] Such refusal to treat would continue to exist so long as discrimination is practiced, be it out of fear, ignorance or prejudice. A public hospital in central Japan had refused to operate on a 22 year old woman from South-East Asia when tests showed that she was infected with HIV.[21] The hospital was quoted as saying it had decided against the operation because it had no instructions on how to conduct operations on AIDS patients.[22] It was also said that her chances of full recovery were slim even if an operation was carried out.[23] The woman was suffering from lower spinal fractures after she had a fall. The patient left for home without being operated on and was suffering from paralysis of the lower half of her body.

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20 This was confirmed by the staff nurse charged with the care of such patients in the Hospital Universiti during the numerous interviews conducted during the field research.

21 The Star, March 12, 1993.

22 It is to be noted that there are occasions where operations have been carried out on Hepatitis B patients. Hepatitis B is fatal and even more infectious than HIV.

23 The fact that the chances of full recovery is slim cannot constitute a valid excuse for refusing to treat.

Before proceeding further, it would be helpful to revert to the various guidelines available.

Under the Hippocratic Oath, it is declared:

> ... I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anybody ...

The Declaration of Geneva states:

> ... I will practise my profession with conscience and dignity;
> The health of my patient will be my first consideration ...
> I will maintain the utmost respect for human life ...

Under the International Code of Medical Ethics, the doctors' duties to their patients are further reaffirmed:

> A doctor must give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care.[24]

It is therefore clear from the above quotations that a doctor owes a duty to treat his patient. This is especially true in

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24 Emphasis is mine.

an emergency. The health of the patient will be the doctor's first consideration, not his own health. A patient who is HIV antibody positive or an AIDS sufferer is to be treated no differently than any other patients. The fact that there is a remote possibility of HIV transmission does not justify the abandonment of the patient by the doctor. This is especially so because the risk of transmission can be substantially minimised by the adoption of the universal precautions which applies to other diseases as well.

Besides the ethical considerations above, there are also legal implications upon such a refusal on the part of the doctor to treat a person infected with HIV or suspected to be so infected. These implications can be traced to the various branches of law - criminal law, civil law and disciplinary measures under the Medical Act 1971.[25]

(2) Criminal Law

There are several possible offences that refusal to treat may amount to, depending on the outcome of such refusal. If death results from the refusal to treat, the doctor may be liable for culpable homicide[26] or murder[27]. This is because under section

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25 Act 50.

26 Penal Code, section 299.

27 Ibid, section 300.

32 of the Penal Code, an 'act' includes illegal omission. As pointed out earlier, the doctor owes a duty to treat his patient. The refusal to treat therefore would be a breach of this duty, making it an illegal omission on the part of the doctor.

Similarly, the offences of voluntarily causing hurt[28] or even grievous hurt[29] may have been committed. The degree of injury or hurt[30] would determine which section it comes under. This is because so long as the elements of the relevant provisions can be proven, the doctor can be prosecuted for such an offence. The crucial element in this particular situation would be the knowledge that the doctor has i.e. that he knew that he is likely by his refusal to treat cause the death or injury to that person.

For example, if a doctor refuses to treat a person because he suspects that person of being infected with HIV and that person was left untreated. The doctor knew that the person need to be attended to otherwise there is a likelihood that he would lose his leg. Yet he refused to treat. As a

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28 Ibid, section 321.

29 Ibid, section 322.

30 Ibid, section 319 describes 'hurt' as bodily pain, disease or infirmity.

result, that person's leg could not be saved subsequently, resulting in him losing his leg. This may fall under section 322 of the Penal Code i.e. voluntarily causing grievous hurt.[31]

The consequence of such a refusal to treat would be the deciding factor in determining whether any offence has been committed by the doctor.

(3) Civil Law

Besides criminal law, there is also a possibility that the doctor may be liable for negligence.[32] If the patient can prove all the elements of negligence in such a situation, he can sue the doctor for negligence. Since there is no dispute that there is a duty of care owed by the doctor to the patient, the refusal to treat would amount to a breach of that duty. The patient need only to prove that as a result of that breach of duty, he had suffered injury. If this can be proven, the doctor would be held to have been negligent and would be ordered to pay damages or compensation.

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31 The various kinds of grievous hurt are as listed down in section 320. It includes emasculation, privation of any member or joint and destruction or permanent impairing of the powers of any member or joint.

32 See Chapter IV, Part B for the discussion on elements of negligence.

(4) Disciplinary Proceeding

The doctor concerned may also have to face disciplinary action. All doctors practising in this country must be registered in accordance with the Medical Act 1971[33] and are subject to the disciplinary jurisdiction of the Malaysian Medical Council. This is stated under section 29 of the said Act.

Section 29 Disciplinary jurisdiction of the Council:

(1) The Council shall have disciplinary jurisdiction over all pesons registered under this Act.

(2) The Council may exercise disciplinary jurisdiction over any registered person who:

(a) has been convicted in Malaysia or elsewhere of any offence punishable with imprisonment (whether in itself only or in addition to or in lieu of a fine);

(b) has been guilty of infamous conduct in any professional respect;

(c) has obtained registration by fraud or misrepresentation;

(d) was not at the time of his registration entitled to be registered; or

33 Act 50.

(e) has since been removed from the register of medical practitioners maintained in any place outside Malaysia.

The relevant paragraphs would be paragraph (a) and (b) of section 29(2) of the Act. If there had been a conviction of any offence punishable with imprisonment, the Council have the jurisdiction to exercise its disciplinary powers.[34] The Council is bound to accept the determination of any court of law as conclusive evidence that the doctor was guilty of the offence of which he was convicted.

Where there had been no criminal proceedings against the doctor, he may be guilty of infamous conduct in any professional respect, also known as professional misconduct. Any abuse of any of the privileges and opportunities afforded to the doctor or any grave dereliction of professional duty or serious breach of medical ethics may give rise to a charge of infamous conduct in a professional respect. The Malaysian Medical Council have grouped it under four main headings:[35]

1. Neglect or disregard of professional responsibilities.

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34 Offences discussed above are punishable with imprisonment.

35 Code of Professional Conduct, Malaysian Medical Council (adopted on the 9th December 1986), at p 10.

2. Abuse of professional privileges and skills.

3. Conduct deregatory to the reputation of the medical profession.

4. Advertising, canvassing and related professional offences.

Refusal to treat based on the fear of being infected by HIV would fall under the first group. As it is the duty of a doctor to treat his patient, such refusal to treat, would amount to the neglect or disregard of professional responsibilities. It is stated under the Code of Professional Conduct that the public is entitled to expect that a registered medical practitioner will provide and maintain a good standard of medical care.[36] This includes:

(a) conscientious assessment of the history, symptoms and signs of a patient's condition;

(b) sufficiently thorough professional attention, examination and where necessary, diagnostic investigation;

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36 Ibid, at p 11.

(c) competent and considerate professional management;

(d) appropriate and prompt action upon evidence suggesting the existence of a condition requiring urgent medical intervention.

As such, an outright refusal to treat would have breached at least one or more of the above. Even if an assessment was made, refusal to treat would mean the non-management of the patient. Appropriate and prompt action would also have been neglected.

If found to be guilty of such infamous conduct in any professional respect, a doctor is liable to a variety of punishments. Under section 30 of the Medical Act 1971[37], the Malaysian Medical Council may, in the exercise of its disciplinary jurisdiction, impose any of the following:

(i) order the name of such registered person to be struck off from the Register; or

(ii) order the name of such registered person to be suspended from the Register for such period as it may think fit; or

37 Act 50.

(iii) order the registered person to be reprimanded; or

(iv) make any such order as aforesaid but suspend the application thereof, subject to such conditions as the Council may think fit, for a period, or periods in the aggregate, not exceeding two years.

In addition, the Council may make an order with regard to the payments of the costs of the Registrar and of any complainant or of the registered person.

The degree of punishment imposed would relate to the seriousness of the infamous conduct in a professional respect as perceived by the Council. If such conduct is viewed to be very serious by the Council, the doctor is liable to be struck off the Register. This would mean that the doctor concerned can no longer practice medicine in Malaysia. If however the Council finds that it is not so serious but a professional misconduct nevertheless, then the doctor may get off with just a reprimand. Whatever the punishment may be, it is conceded that a disciplinary action against a doctor in such

circumstances may be far more effective and simpler than prosecuting the doctor under criminal law or suing him for negligence.[38]

A disciplinary proceeding against a doctor merely requires a complaint to be lodged against the doctor by the patient. Once this is done, a Committee will be set up to investigate the complaint and establish the facts of the said case.

It is undeniable however that whatever the action against the doctor may be, the result would leave an indelible impact as it affects the reputation and livelihood of the said doctor.

It is submitted that due to the unique feature of the undertaking to treat and care for the sick, this obligation extends to the other health care workers as well. The unsubstantiated fear of being infected should not be allowed to prevail resulting in discrimination in the form of refusal to treat the patients. Since the scope of the duty to treat and care for the sick encompasses the risk of being exposed to the

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38 Under criminal law, the burden of proof is on the prosecution and the standard is beyond reasonable doubt whereas in the civil action, eventhough the burden is not as high, i.e. on the balance of probabilities, the plaintiff still need to prove all the elements of the cause of action.

various diseases, it does not justify selective treatment based on the type of disease. It would not only be unethical on the part of the doctor and other health care workers to refuse to treat a patient who is HIV antibody positive or suspected to be so because this group of persons have undertaken the task to treat patients regardless of creed, age or sex, it would also entail with it legal consequences as pointed out above. What can be done is the adoption of universal precautions in all such cases to minimise the risk of transmission.

CHAPTER VII

CONCLUSION AND PROPOSALS

Legal and non-legal dilemmas surrounding the subject of HIV/AIDS present researchers with the challenge of involvements in complex issues. An increasing number of cases concerning difficult application of available (or what is considered presently available) laws are capturing the legal and public imagination. Indeed, increasingly the courts are going to be faced with interesting (hitherto unsolved) issues before them. Much of this thesis is devoted to an analysis of some of the problems which HIV/AIDS poses for the legal system generally, and the trial (civil and criminal) process particularly. These problems range from handling of conflicting rules to the need for institutional reform and adoption of administrative, medical and educational support programmes and mechanisms that will provide effective and adequate assurance for the integrity of sufferers from HIV/AIDS, medical personnel and the general public. These and other related issues are explored and evaluated in the thesis.

More specifically, many indications have already been given of the necessity to clarify, reconsider and reform both law and policies governing HIV/AIDS in the foregoing chapters. It remains now in this concluding chapter to bring together and to highlight some of the broader aspects and to consider a number of proposals and their impact for future development.

Issues that have arisen and may arise insofar as HIV transmission and AIDS are concerned affect the social, economic, medical and legal aspects of not only HIV infected persons and persons with AIDS but also their families, friends, employers and co-employees and ultimately society generally. Chapters III and IV have outlined these processes.

Uncertainty as to the risks of developing AIDS for those who are HIV infected is a major consideration but this seems to have been overlooked in many instances. As such, this has resulted in unnecessary complications of an existing complex situation where fear and prejudice have resulted in discriminative actions against those who are HIV infected and AIDS patients. Ignorance has further compounded the problems facing these people and society. Situations where HIV/AIDS related problems may arise are unlimited as there is no age, sex, race, cultural, economic or geographical boundary or barrier to HIV infection/AIDS. Technological limitation must also be acknowledged and these certainly do not alleviate the surrounding uncertainties. There are many unanswered questions

at the moment. Despite tenacious "detective" work by the world's best scientific and medical researchers, HIV/AIDS remain one of the most mysterious maladies ever to confront medical science. The more researchers learn about the disease, the more questions they have.[1]

Bearing in mind the fact that Malaysia is a developing country, it is crucial that prevailing local conditions be given due regard and priority before adopting any measures (legal and otherwise) that have been taken in other jurisdictions. In introducing measures to deal with problems associated with HIV transmission and AIDS, several factors must be taken into consideration - available finance, trained personnel to carry out such measures, technological development, practicality and social, cultural and religious acceptability. In particular, the sectors that would and should be involved are the Ministry of Health, Ministry of Education, Immigration Department, prison authorities, other corrective or rehabilitative authorities and religious organisations. More importantly however, is the participation of individuals, family members and the community generally. This is particularly so because the success of whatever actions or programmes introduced by the various authorities are subject to

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1 "Invincible AIDS", Time Magazine, August 3, 1992, No. 31 at pp. 17, 20.

the application of such programmes and their acceptance by the individuals, family members and society generally.

The human aspect is probably the most crucial factor to be taken into consideration as the main aim in most actions are geared towards encouraging the change in high risk behaviour which is within the control of individual persons. Further, it is noted that change of behavioural patterns are difficult to achieve. Human nature is such that once the behavioural pattern is set e.g. sexual promiscuity, it is extremely difficult to change. It depends almost entirely on the individuals concerned to put in the effort to change his behaviour. Nevertheless, actions and programmes can be formulated to create awareness and hopefully encourage the change of high risks behaviour. Awareness of the risks of HIV transmission will hopefully discourage those who are yet uninfected from venturing into high risk activities such as casual sex and drug abuse. The scope of this thesis is confined mainly to the legal aspects associated with HIV/AIDS. As such, the proposals and recommendations are not solutions to the various problems highlighted in the earlier chapters. They are merely suggestions that can be carried out to alleviate and hopefully improve the present unsatisfactory legal implications.

Proposals and recommendations fall under (a) legislative intervention; (b) judicial discretion and public policy and the extra-legal measures under (c) miscellaneous.

A. Legislative Intervention

1. Criminal Law

Present law seem ill-equipped to deal with legal issues associated with HIV/AIDS. The social sanction and prejudice against HIV/AIDS have resulted in making HIV/AIDS stand in a class of its own compared to other infectious diseases. In the criminal law area, the difficulty in proving the mode and the exact time of HIV transmission make it almost impossible to prove any of the possible offences under the Penal Code.[2]

Lack of materially acceptable evidence in law and coupled with the difficulty in affirming the chain of causation provide difficulties for a successful prosecution. For instance, the offence of spreading HIV may fall under sections 269 and 270 of the Penal Code and section 12(2) of Prevention and Control of Infectious Diseases Act 1988. To date, there has been no known prosecution for this act.

Lack of personnel and the remote chance of a successful prosecution have probably contributed to the fact that there has been no such prosecution. Further, the policy of the Ministry of Health to prevent and control HIV infection does not encourage the prosecution of such 'offenders'. It is

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2 See Chapter IV, Part C and Chapter V.

an acknowledged fact that persuasion to change high risk behaviour would be more effective than prosecution of the 'offender' in the Plan of Action to prevent and control HIV transmission. This does not mean however, that behavioural change is an easy task to achieve.

It is acknowledged that prosecution of the 'offender' is not a solution to the problem of HIV transmission. Nevertheless, using the existing legal framework, to facilitate the prosecution, perhaps one proposal could be to adopt legal presumptions for the offence of spreading HIV. The act can be made to be an offence in itself. In other words, it can be a strict liability offence. If strict liability is adopted in such a case, the burden of disproving the fact would fall on the accused person. Similar presumptions have been implemented for drug trafficking offences.

Although it is improbable that euthanasia would be legalized in this country, this point has been explored in this thesis to show the possibility of such cases being regulated by law. AIDS cases may or may not fall under the category of 'terminally ill". This is because such cases vary in terms of the infections and/or cancer that developed. Further, the element of extreme or distressing pain and suffering may not be present in AIDS cases. Nevertheless, such requests may be forwarded to the doctor or other health care members. At present where a patient refuses treatment and requests to be

allowed to die in peace, the practice is to discharge 'at own risk' such patients. Such a contractual term to oust the legal obligation of the doctor is resorted to due to lack of any other alternatives. It acts as a legal 'protection' for doctors. As such, good medical practice would remain the major element in the dealing of such cases. In fact, it is better under the circumstances to leave it to good medical practice as has been practiced all the while.

In addition to good medical practice, a practical solution would be to decriminalize compassionate murder and suicide. The element of motive and good faith should be taken into consideration. This would ensure the non-prosecution of the medical practitioner or the health care team when good medical practice is adhered to. A more legalistic approach would be to legalize euthanasia. This would entail the introduction of new legislation such as Euthanasia Act, Natural Death Act and recognition of living wills as in certain states in the United States and Australia. The substantial legal reform is perhaps unnecessary in view of the fact that euthanasia is an accepted form of practice in Malaysia although it is not legally recognised. Furthermore, the introduction of such legislation would necessitate the setting up of mechanisms to carry out the regulations to be introduced. Such legalistic approach, if adopted here, would in all probabilities complicate the issue and burden the patient and his relatives.

2. Civil Law

In the case of civil law, it may be necessary to introduce a legal obligation on the part of those who are HIV-infected or AIDS sufferers to inform their partners of their status through legislation i.e. Prevention and Control of Infectious Diseases Act 1988. This is in addition to the present law[3] which makes it an offence to spread HIV. With the existence of such legal obligation, it would ease the burden of proving duty of care and the breach of the duty in negligence cases.

A further proposal is to make it a legal obligation to inform the partners of persons tested positive for HIV via contract. The consent of the HIV infected person for his partner(s) to be so informed can be made a prerequisite to the HIV test. This can be incorporated in the existing consent form.[4]

As for the tortious field, it would also be necessary to extend the limitation period for tort actions as it may take years before actual injury (in the form of infections and

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3 Sections 269 and 270 of Penal Code and section 12(2) of Prevention and Control of Infectious Diseases Act 1988.

4 The proposal to make it a legal obligation to inform their partners can and should be extended to other infectious diseases which are equally fatal in the long run such as syphillis and Hepatitis B.

cancers) sets in.[5] Data collected so far by the World Health Organisation from various countries can be analysed to determine a more realistic limitation period for HIV/AIDS in negligence cases. An extension of up to twelve years can be set and should be subject to review in line with scientific and medical development. Similar considerations ought to be given to cases involving various types of pollution and radiation as these result in more 'injurious' consequences but may take a long time before they can be detected. Perhaps, a special class of injury can be created which sets aside the requirement of a limitation period.

B. Judicial Discretion and Public Policy

HIV/AIDS challenges the judicial law-making in dealing with the legal problems associated with HIV/AIDS within the confines of existing law which did not have HIV in mind when it was first legislated. In many instances such inadequacy or insufficiency of the law can only be remedied by the application of judicial discretion and public policy. Issues of confidentiality, partner notification, termination of employment, rejection of insurance policy and various offences under the criminal law have been analysed in this thesis. It is simply not practical to enact legislation in each and every legal issue concerning

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5 Cases which involve pollution and radiation would also benefit from the extension of the limitation period as the effects of such exposure take years to culminate.

HIV/AIDS. These issues have to be dealt with through existing legislation and judicial pronouncements. As already seen above, HIV/AIDS touches upon a wide spectrum of legal issues: from employment, insurance, family and negligence laws to various offences under criminal law. Discussion in earlier chapters have highlighted the difficulties of applying the law to the various situations involving HIV/AIDS.

However, judges can still play an active and meaningful role in such situations. For example, the concept of mutual trust and confidence in employment law can be expanded and applied in HIV/AIDS cases.[6] For negligence cases, causation would be difficult to prove and the limitation period may hinder the action. The element of injury would be difficult to satisfy. Is HIV transmission per se an 'injury'?[7] Exercise of judicial discretion and expansion of public policy application can be adopted to cover hitherto areas where courts have either been reluctant or judges "unadventurous" enough to pronounce upon such issues as in other jurisdiction where courts have ventured into expanding and evolving legal concepts to cover wrongful life or death cases.[8]

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6 See Chapter III, Part A.

7 Similar difficulties are faced in other sexually transmitted diseases.

8 Such expansion of public policy application can be seen in cases such as Gillick v West Norfold and Wisbech Area Health Authority [1985] 3 All ER 402.

Similarly, in dealing with criminal cases linked with HIV/AIDS, judicial discretion can play a role in sentencing of offenders. Where a convicted person suffers from AIDS and needs constant medical care and attention, it would perhaps be more practical to utilise alternatives to imprisonment such as bond of good behaviour. If a person who knew he is infected with HIV commits rape, the fact that he is HIV infected may be considered an aggravating factor.[9] The aims and objectives of criminal law may have to be re-assessed in such cases.

Public policy is also a useful concept to employ in judicial law-making. For example, protection of public health is a public policy which can be used to justify the curbing of an individual's rights. In particular, this can be utilised in the partner notification programme to justify breach of confidentiality. Non-discrimination against HIV/AIDS sufferers can similarly be made a public policy in furtherance of the constitutional right of equality before the law. Discrimination in the employment sector, education and travelling can therefore be curbed to that extent.

C. **Miscellaneous**

While legislation and judicial activities are highly necessary towards providing effective measures in the prevention and

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9 See Chapter V, Part E.

curbing the spread of HIV/AIDS, these by themselves are not sufficient. Laws do not operate in a vacuum. They cannot offer any legal solution except in the perspective of society at large. It seems reasonable therefore to suggest that other institutional and societal support programmes need to be evolved to assist in "giving life" to laws. These include public education, supportive actions, good medical practice and other related community-based programmes.

1. Public Education

The importance of proper public education cannot be emphasised often enough. Correct information and facts concerning HIV/AIDS will assist towards creating a proper understanding of the problems associated with it. Such understanding is crucial to ensure that blind discrimination does not result. The minimisation of discriminative actions will also greatly enhance and further the aim of controlling the spread of HIV/AIDS. The World Health Organisation (WHO) have taken a series of strong and proactive stands to help protect the rights of, and prevent discrimination against, persons infected with HIV.[10] WHO Member States are urged to 'foster a spirit of understanding and compassion for HIV-infected people and people

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10 This was reinforced by the 41st World Health Assembly which adopted a resolution on 13 May 1988 entitled "AIDS: Avoidance of Discrimination in Relation to HIV-Infected People and People with AIDS".

with AIDS through information, education and social support programmes.' There is a strong and clear public health rationale for this stand. HIV spreads almost entirely through identifiable behaviour and specific actions (sexual intercourse and intravenous drug use) which are generally, though not always, subject to individual control. A change in behaviour of either the HIV-infected or the uninfected person will be sufficient to prevent HIV transmission. Each individual in society plays a crucial role in ensuring that he does not contribute to the spread of HIV through ignorance - be it by infecting others or being infected by another.

The current effort by the Ministry of Health in producing short documentaries and advertisements in various forms to educate the public is a move in the right direction. Participation and cooperation from other Ministries (especially the Ministry of Information) at all levels are needed to ensure the success of such a scheme. It has been acknowledged by the World Health Organisation that the most effective way of controlling the spread of HIV in the long run is via proper education of the general public.

Ideally, the subject of HIV/AIDS should be readily and openly discussed at all levels inter alia in schools, at home and at work. Besides informative discussions, various projects and activities can be organised. This may be in the form of debates, forums, art competitions, essay writing, exhibitions

and games. However, Malaysian public may not be ready for such an extensive and open discussion as it involves the subject of sexual behaviour and drug abuse. Social, economic and religious aspects have to be considered. Political commitment would also play an important role in such a programme.

Healthy living should be encouraged. The current campaign by the government should be continued. Although moral education plays an important role since sexual intercourse is presently one of the known modes of transmission, it should not be utilised to label those who are already infected as being immoral as infection can also be via blood transfusion and through mothers i.e. pregnancy and perinatal. Such actions would not further the main aim of bringing the spread of HIV/AIDS under control. Besides, condemning HIV infected persons and AIDS sufferers would be harmful as these people play a very important role in ensuring that they do not contribute to the spreading of HIV/AIDS.

2. Other Supportive actions

At present, the Ministry of Health conducts screening of various high risks groups.[11] They include prisoners, drug addicts in rehabilitation centres, prostitutes in corrective centres and patients with certain diseases such as

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11 A better approach is to focus on high risk behaviour.

tuberculosis, sexually transmitted diseases and mental afflictions. The main aim of screening is to collect data. It is noted that there is insufficient supportive actions after screening. Haphazard management of HIV infected persons in prisons and other institutions would be counter-productive to any plan to control the spread of HIV/AIDS.

Although supportive actions involve mainly the administrative authorities, they should not be left without guidance and support, be it in terms of power to carry out such activities, trained personnel or finance. Supportive actions include post-counselling and proper management of HIV-infected persons. Such measures are costly and require political support and commitment. Presently, drastic measures such as isolating HIV-infected persons have been resorted to in some instances as there is fear of HIV being spread to others via sexual activities among inmates which cannot be totally curbed. Although it is not within the scope of this thesis to suggest what supportive actions should be taken and the ways and means to implement them,[12] it is hoped that the relevant authorities would take such actions. Efforts should be doubled in this respect as screening alone without any supportive actions defeats the purpose. What is the point of knowing how many people are infected with HIV if efforts are not made to

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12 A thorough study of the methods and procedures should be conducted, taking into consideration the peculiarities of a particular institution.

control the spread by helping these people first? Lessons can learnt from other countries where supportive actions have been successfully implemented. However, local conditions need to be kept in mind. For example, the move of providing condoms for prisoners and ensuring the availability of injection equipments have been introduced in some developed countries. Would this be acceptable here? Various facets need to be considered: its practicality, economics and social and religious acceptability.

3. Good medical practice

Given the fact that scientists are still trying to discover and learn more about HIV, statutory intervention at every level is perhaps inappropriate. Good medical practice is needed instead as it provides flexibility to change with development in science.

In view of uncertainties surrounding HIV/AIDS, it is necessary for those in the medical profession to carry out good medical practice based on existing ethical codes binding them. Where the law and ethical codes do not provide any assistance or solution to the dilemma faced by medical practitioners, it is for the medical profession to take the initiative to consider the matter and issue a statement to provide a guideline to fellow practitioners. The Malaysian Medical Council and the Malaysian Medical Association can both adopt a

more dynamic approach towards this end. References can be made to statements made by the medical profession in other countries with regards to similar issues. The stand taken by the WHO ought be adopted by the body governing the medical profession.

Confidentiality is of utmost priority except where there is a legal obligation to inform the authorities. There is also an overriding duty to society that justifies such a breach of confidentiality e.g. partner notification.

It is an offence for a medical practitioner to assist euthanasia in any way. It remains good medical practice however, to respect the patient's wishes insofar as treatment is concerned. It is for the medical practitioner to treat and administer drugs accordingly in HIV/AIDS cases.

4. Family planning

It may be useful to include HIV-test in the standard maternal and child health programme. This would enable early detection of such an infection and would enable the doctor and the patient to take preventive measures in the future. For instance, a woman who is desirous of starting a family can be given proper counselling and advice if found to be HIV-antibody positive. Measures to prevent the infection being spread unknowingly to the child and others can be employed. The risks of infecting others can thus be minimised. This move however,

would be very costly if it is to be implemented on the national scale. The question of consent must also be resolved before such a programme is adopted.

5. Programmes on sexually transmitted diseases

The HIV-test can also be made part of the routine tests to be carried out on persons who are suspected of suffering from sexually transmitted diseases. Early detection in this manner would assist in the proper management of the patients subsequently. Pre and post counselling should also be part and parcel of the programme.

6. Pre-marriage test

There is no legal requirement for the HIV-test to be conducted prior to marriage. However, it may be useful especially in view of the fact that there is no legal obligation on the part of the HIV-infected person to inform his/her spouse of his/her seropositivity. This is despite the existence of the window period.[13] This measure is necessary as there are people who are not aware of their own seropositivity. To avoid further complications at a later date, it is advisable to introduce it as a routine pre-marriage test. The cost of the test can be charged to the couple concerned. This would, however, remain a

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13 cf "Pre-marriage health tests not practical", New Straits Times, November 25, 1992, at p 10.

short-term measure as the test merely shows that person's status at that point of time. The onus is on the couple to maintain a healthy lifestyle. High risks behaviour otherwise would expose them to the risks of HIV transmission.[14]

7. Human rights

Protecting the human rights and dignity of HIV-infected persons and those suffering from AIDS is a necessity for effective public health programmes to prevent and control HIV/AIDS. This is because the protection of the uninfected majority depends upon and is inextricably bound with the protection of the rights and dignity of the infected person. As such, all the actions and proposals suggested must respect the human rights and dignity of HIV-infected person and those with AIDS. The respect for human rights stems from the fundamental principle that society in all its activities must preserve the basic dignity of the human person.

Virtually all aspects of human rights are involved in the responses to AIDS and these give rise to complex problems which include:[15]

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14 "Min. Ruling on AIDS test for would-be couples?" The Malay Mail, 1st November, 1991, at p 5.

15 Universal Declaration of Human Rights.

(1) right to life, liberty and security of persons,

(2) right to privacy,

(3) right to freedom of movement,

(4) right to marry and found a family,

(5) right to work,

(6) right to education.

Although difficult choices are often encountered in taking actions to prevent and control HIV infection, it is crucial to keep in mind the need to respect basic human rights.

Combating AIDS is not confined to medical experts, scientist, government officials and health personnel. Each and every one needs to be involved in the programme to prevent and control HIV infection and AIDS. The role of family is especially pertinent. This is even so in Malaysia where the family unit can be utilised to inculcate good values and a healthy lifestyle. Ultimately, this would prove to be more effective in the long run. Programmes or actions suggested above invariably involve substantial costs; be it personnel, time or finance.

Human rights have to be included as a complement and reinforcement of public health principles. The importance of promoting human-rights cannot be over-emphasized. The Plan of Action for the Prevention and Control of AIDS ought to be brought in line with the promotion of human rights to ensure long-term effectiveness.

The above conclusions and proposals represent in summary some of the more salient issues explored and evaluated in this thesis. Obviously, these are merely intended to provide an overview of the associated problems and as such are not intended to be an exhaustive account thereof.

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Appendix 1

1987 REVISION OF CDC/WHO CASE DEFINITION FOR AIDS SURVEILLANCE PURPOSES

For national reporting, a case of AIDS is defined as an illness characterized by one or more of the following "Indicator" diseases, depending on the status of laboratory evidence of HIV infection, as shown below.

I. WITHOUT LABORATORY EVIDENCE REGARDING HIV INFECTION

If laboratory tests of HIV were not performed and gave inconclusive results (see Appendix 1.1) and the patient had no other cause of immunodeficiency listed in Section 1.A below, then any disease listed in Section 1.B indicates AIDS if it was diagnosed by a definitive method (see Appendix 1.2).

A. Causes of immunodeficiency that disqualify diseases as indicators of AIDS in the absence of laboratory evidence for HIV infection.

1. High-dose or long-term systematic corticosteriod therapy or other immunosuppressive/cytotoxis therapy < 3 months before the onset of the indicator disease.

2. Any of the following diseases diagnosed <3 months after diagnosis of the indicator disease: Hodgkin's disease, non-Hodgkin's lymphoma (other than primary brain lymphoma), lymphocytic leukaemia, multiple myeloma, any other cancer of lymphoreticular or histiocytic tissue, or angioimmunoblastic lymphadenopathy.

3. A genetic (congenital) immunodeficiency syndrome or an acquired immunodeficiency syndrome a typical of HIV infection, such as one involving hypogammaglobulinaemia.

B. Indicator diseases diagnosed definitively (see Appendix 1.2).

1. Candidiasis of the oesophagus, trachea, bronchi, or lungs.

2. Cryptococcosis, extrapulmonary.

3. Cryptosporidiosis with diarrhoea persisting > 1 month.

4. Cytomegalovirus disease of an organ other than liver, spleen, or lymph nodes in a patient > 1 month of age.

5. Herpes simplex virus infection causing a mucocutaneous ulcer that persists > 1 month; or bronchitis, pneumonitis, or oesophagitis for any duration affecting a patient > 1 month of age.

6. Kaposi's sarcoma affecting a patient < 60 years of age.

7. Lymphoma of the brain (primary) affecting a patient < 60 years of age.

8. Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia (LIP/PLH complex) affecting a child < 13 years of age.

9. Mycobacterium avium complex or M. kansasii disease, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes).

10. Pneumocystis carinii pneumonia.

11. Progressive multifocal leukoencephalopathy.

12. Toxoplasmosis of the brain affecting a patient > 1 month of age.

II. WITH LABORATORY EVIDENCE FOR HIV INFECTION

Regardless of the presence of other causes of immunodeficiency (I.A.), in the presence of laboratory evidence of HIV infection (see **Appendix 1.1**) any disease listed above (I.B) or below (II.A or II.B) indicates a diagnosis of AIDS.

A. Indicator diseases diagnosed definitively (see **Appendix 1.2**).

1. Bacterial infections, multiple or recurrent (any combination of at least 2 within a 2-year period) of the following types affecting a child < 13 years of age:

   septicaemia, pneumonia, meningitis, bone or joint infection, or abscess of an internal organ or body cavity (excluding otitis media or superficial skin or mucosal abscesses), caused by Haemophilus, Streptococcus (including pneumococcus), or other pyogenic bacteria.

2. Coccidioidomycosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes).

3. HIV encephalopathy (also called "HIV dementia", "AIDS dementia" or "subacute encephalitis due to HIV") (**See Appendix 1.2** for description).

4. Histoplasmosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes).

5. Isosporiasis with diarrhoea persiting > 1 month.

6. Kaposi's sarcoma at any age.

7. Lymphoma of the brain (primary) at any age.

8. Other non-Hodgkin's lymphoma of B-cell or unknown immunological phenotype and the following histological types:

   a. small noncleaved lymphoma (either Burkitt or non-Burkitt type);

   b. immunoblastic sarcoma (equivalent to any of the following, although not necessarily all in combination: immunoblastic lymphoma, large-cell lymphoma, diffuse histiocytic lymphoma, diffuse undifferentiated lymphoma, or high-grade lymphoma).

   Note:

   Lymphomas are not included here if they are of T-cell immunological phenotype or their histological type is not described or is described as "lymphocytic", "lymphoblastic", "small cleaved", or "plasmacytoid lymphocytic".

9. Any mycobacterial disease caused by mycobacteria other than M. tuberculosis, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes).

10. Disease caused by M. tuberculosis, extrapulmonary (involving at least 1 site outside the lungs, regardless or whether there is concurrent pulmonary involvement).

11. Salmonella (nontyphoid) septicaemia, recurrent.

12. HIV wasting syndrome (emaciation, "slim disease") (see **Appendix 1.2** for description).

B. Indicator diseases diagnosed presumptively (by a method other than those in **Appendix 1.2**).

Note:

Given the seriousness of diseases indicative of AIDS, it is generally important to diagnose them definitively, especially when therapy that would be used may have serious side effects or when

definitive diagnosis is needed for eligibility for antiretroviral therapy. Nonetheless, in some situations, a patient's condition will not permit the performance of definitive tests. In other situation, accepted clinical practice may be to diagnose presumptively based on the presence of characteristic clinical and laboratory abnormalities. Guidelines for presumptive diagnosis are suggested in **Appendix 1.3.**

1. Candidiasis of the oesophagus.

2. Cytomegalovirus retinitis with loss of vision.

3. Kaposi's sarcoma.

4. Lymphoid intersititial pneumonia and/or pulmonary lymphoid hyperplasia (LIP/PLH complex) affecting a child < 13 years of age.

5. Mycobacterial disease (acid-fast bacilli with species not identified by culture), disseminated (involving at least 1 site other than or in addition to lungs, skin, or cervical or hilar lymph nodes).

6. Pneumocystis carinii pneumonia.

7. Toxoplasmosis of the brain affecting a patient > 1 month of age.

III. **WITH LABORATORY EVIDENCE AGAINST HIV INFECTION**

With laboratory test results negative for HIV infection (see **Appendix 1.1**), a diagnosis of AIDS for surveillance purposes is ruled out unless:

A. all the other causes of immunodeficiency listed above in Section 1.A are excluded; AND

B. the patient has had either:

1. Pneumocystis carinii pneumonia diagnosed by a defenitive method (see **Appendix 1.2**);

OR

2. a. any of the other diseases indicative of AIDS listed above in Section 1.B diagnosed by a definitive method (see **Appendix 1.2**);

AND

b. T-helper/inducer (CD4) lymphocyte count < 400/mm^3.

Appendix 1.1

LABORATORY EVIDENCE FOR OR AGAINST HIV INFECTION

1. FOR INFECTION

When a patient has disease consistent with AIDS:

a. a serum specimen from a patient > 15 months of age, or from a child < 15 months of age whose mother is not thought to have had HIV infection during the child's perinatal period, that is repeatedly reactive for HIV antibody by a screening test (e.g., Western blot, immunofluorescence assay), if done, are positive; OR

b. a serum specimen from a child < 15 months of age, whose mother is thought to have had HIV infection during the child's perinatal period, that is repeatedly reactive for HIV antibody by screening test (e.g., ELISA), plus increased serum immunoglobulin levels and at least 1 of the following abnormal immunological test results: reduced absolute lymphocyte count, depressed CD4 (T-helper) lymphocyte count, or decreased CD4/CD8 (helper/suppressor) ratio, as long as subsequent antibody tests (e.g., Western blot, immunofluorescence assay), if done, are positive; OR

c. a positive test for HIV antigen; OR

d. a positive HIV culture confirmed by both reverse transcriptase detection and specific HIV-antigent test or in situ hybridization using a nucleic acid probe; OR

e. a positive result on any other highly specific test for HIV (e.g., nucleic acid probe or peripheral blood lymphocytes).

2. AGAINST INFECTION

A nonreactive screening test for serum antibody to HIV (e.g., ELISA) without a reactive or positive result on any other test for HIV infection (e.g., antibody, antigen, culture), if done.

3. INCONCLUSIVE (NEITHER FOR NOR AGAINST INFECTION)

a. a repeatedly reactive screening test for serum antibody to HIV (e.g., ELISA) followed by a negative or inconclusive supplemental test (e.g., Western blot, immunofluorescence assay) without a positive HIV culture or serum antigen test, if done; OR

b. a serum specimen from a child < 15 months of age, whose mother is thought to have had HIV infection during the child's perinatal period, that is repeatedly reactive for HIV antibody by a screening test, even if positive by a supplemental test, without additional evidence for immunodeficiency as described above (in 1.b) and without a positive HIV culture or serum antigen test, if done.

Appendix 1.2

DEFINITIVE DIAGNOSTIC METHODS FOR DISEASES INDICATIVE OF AIDS

DISEASES	DEFINITIVE DIAGNOSTIC METHODS
Cryptosporidiosis Cytomegalovirus Isosporiasis Kaposi's sarcoma Lymphoma Lymphoid pneumonia or hyperplasia Pneumocystis carinii pneumonia Progressive multi-focal leukoencephalopathy Toxoplasmosis	Microscopy (hostology or cytology)
Candidiasis	Cross inspection by endoscopy or autopsy or by microscopy (histology or cytology) on a specimen obtained directly from the tissues affected (including scrapings from the mucosal surface), not from a culture.
Coccidioidomycosis Cryptococcosis Herpes simplex virus Histoplasmosis	Microscopy (hostology or cytology), culture, or detection of antigen in a specimen obtained directly from the tissues affected or a fluid from those tissues.
Tuberculosis Other mycobacteriosis Salmonellosis Other bacterial infection	Culture

HIV encephalopathy* (demential)	Clinical findings of disabling cognitive and/or motor dysfunction interfering with occupation or activities of daily living, or loss of behavioural developmental milestrones affecting a child, progressing over weeks to months in the absence of a concurrent illnesses and conditions must include cerebrospinal fluid examination and either brain imaging (computed tomography or magnetic resonance) or autopsy.

Appendix 1.3

SUGGESTED GUIDELINES FOR PRESUMPTIVE DIAGNOSIS OF DISEASES INDICATIVE OF AIDS

DISEASES	PRESUMPTIVE DIAGNOSIS CRITERIA
Candidiasis of oesophagus	a. Recent onset of retrosternal pain on swallowing; AND b. oral candidiasis diagnosed by the gross appearance of white patches or plaques on an erythematous base or by the microscopic appearance of fungal mycelial filaments in an uncultured specimen scraped from the oral mucosa.
Cytomegalovirus retinitis	A characteristic apperance on serial ophthalmoscopic examinations (e.g., discrete patches of retinal whitening with distinct borders, spreading in a centrifugal manner, following blood vessels, progressing over several months, frequently associated with retinal vasculitis, haemorrhage, and necrosis). Resolution of active disease leaves retinal acarring and atrophy with retinal pigment epithelial mottling.
Mycobacteriosis	Microscopy of a specimen from stool or normally sterile body fluids or tissue from a site other than lungs, kin, or cervical or hilar lymph nodes, showing acid-fast bacilli of a specie not identified by culture.
Kaposi's sarcoma	A characteristic gross appearance of an erythematous or violaceous plaque-like lesion on skin or mucous membrane. (Note: Presumptive diagnosis of Kaposi's sarcoma should not be made by clinicians who have seen few cases of it).

Lymphoid interstitial pneumonial	Bilateral reticulonodular interstitial pulmonary infiltrates present on chest X-ray for > 2 months with no pathogen identified and no response to antibiotic treatment.
Pneumocystis Carinii pneumonia	a. A history of dyspnea on exertion or nonproductive cought of recent onset pneumonia (within the past 3 months); AND b. chest X-ray evidence of diffuse bilateral interstitial infiltrates or gallium scan evidence of diffuse bilateral pulmonary disease; AND c. arterial blood gas analysis showing an arterial $pO_2$of.70 mm Hg or a low respiratory diffusing capacity (<80% of predicted values) or an increase in the alveolar-arterial oxygen tension gradient; AND d. no evidence of a bacterial pneumonia.
Toxoplasmosis of the brain	a. Recent onset of a focal neurological of the brain abnormality consistent with intracranial disease or a reduced level of consciousness; AND b. brain imaging evidence of a lesion having a mass effect (on computed tomography or nuclear magnetic resonance) or the radiographic appearance of which is enhanced by injection of contrast medium; AND c. serum antibody to toxoplasmosis or successful response to therapy for toxoplasmosis.

Appendix 2

LIST OF SCREENING CENTRES IN MALAYSIA
(as at 31st December 1992)

A. Peninsular Malaysia

1. Pusat Perkhidmatan Darah, Hospital Besar, Kuala Lumpur
2. Hospital Tengku Ampuan Rahimah, Klang
3. Hospital Daerah, Kajang
4. Hospital Daerah, Kuala Kubu Bharu
5. Hospital Besar, Seremban
6. Hospital Besar, Melaka
7. Hospital Daerah, Muar
8. Hospital Daerah, Batu Pahat
9. Hospital Sultanah Aminah, Johor Bahru
10. Hospital Besar, Kuantan
11. Hospital Daerah, Mentakab
12. Hospital Besar, Kuala Trengganu
13. Hospital Besar, Kota Bharu
14. Hospital Besar, Kangar
15. Hospital Besar, Alor Setar
16. Hospital Daerah, Sungai Petani
17. Hospital Besar, Pulau Pinang
18. Hospital Daerah, Bukit Mertajam
19. Hospital Daerah, Taiping
20. Hospital Besar, Ipoh
21. Hospital Daerah, Teluk Intan
22. Hospital Daerah, Tapah
23. Hospital Universiti, Kuala Lumpur
24. Institut Penyelidikan Perubatan, Kuala Lumpur
25. Universiti Sains Malaysia, Pulau Pinang

B. Sarawak

1. Pusat Makmal Perubatan, Kuching
2. Hospital Daerah, Miri
3. Hospital Daerah, Sibu
4. Hospital Bahagian Sri Aman*
5. Hospital Besar, Limbang*
6. Hospital Besar, Sarikei*
7. Hospital Besar, Kapit*
8. Hospital Daerah, Lundu*
9. Hospital Daerah, Serian*
10. Hospital Daerah, Saratok*
11. Hospital Daerah, Mukah*
12. Hospital Daerah, Kanowit*
13. Hospital Daerah, Bintulu*
14. Hospital Daerah, Marudi*
15. Hospital Daerah, Lawas*

C. Sabah

1. Hospital Besar, Kota Kinabalu
2. Hospital Besar, Tawau
3. Duchess of Kent Hospital, Sandakan
4. Hospital Daerah, Kudat
5. Hospital Daerah, Keningau
6. Hospital Daerah, Beaufort*
7. Hospital Daerah, Beluran*
8. Hospital Daerah, Kota Belud*
9. Hospital Daerah, Labuan*
10. Hospital Daerah, Lahat Datu*
11. Hospital Daerah, Papar*
12. Hospital Daerah, Ranau*
13. Hospital Daerah, Semporna*
14. Hospital Daerah, Tambunan*
15. Hospital Daerah, Tenom*

Note: All screening centres are using the EIA testing except for the centres marked (*) which are using the Particle Agglutination Assay.

APPENDIX 3

The following are the acceptable methods of diagnosing infectious complications in AIDS patients.

DISEASES/CONDITIONS SUGGESTIVE OF AIDS	ACCEPTABLE METHODS
Kaposi s sarcoma, any site	Biopsy with histologic diagnosis.
Primary lymphoma of brain (exclude generalized lymphoma with metastasis)	Biopsy with histologic diagnosis.
Pneumocystis carinii pneumonia	Biopsy with histologic diagnosis; Microscopy of "touch" preparation or bronchial washings.
Toxoplasmosis, encephalitis or pneumonia	Histology; Microscopy of "touch" preparation.
Cryptosporidiosis, intestinal with diarrhoea persisting for > 1 month	Biopsy with histologic diagnosis; Microscopy of stool specimen.
Candida, esophagitis only	Direct endoscopic examination; Microscopy of "wet" preparation from esophagus.
Cryptococcosis – blood, multiple organs, meningeal; exclude pulmonary only	Culture Antigen detection; Histology, India ink preparation of CSF.
Mycobacterial infection (nontubercular and non-leprae), symptomatic, disseminated infection; exclude pulmonary.	Culture
Cytomegalovirus infection, symptomatic, causing disease of lungs, intestine, central nervous system (exclude mononucleosis syndrome)	Histologic diagnosis only; Serologic titers are not diagnostic of disease.
Herpes simplex ulceration (ulcer persistent or spreading for > 1 month exclude vesicular lesions); Persistent herpetic disease of lungs, intestine, internal organs; exclude encephalitis only.	Culture of lesion; Histology; Cytology
Progressive multifocal leukoencephalopathy (presumed to be caused by Papovavirus)	Biopsy with histologic diagnosis

Contact the State Pathologist whenever the above tests are needed.

GUIDELINES FOR LABORATORY DIAGNOSIS OF HIV INFECTION

In order to carry out antibody detection and T-cell enumeration tests, the following procedures should be adhered to ensure safety and reliable results.

1. **HIV Antibody Tests: (ELISA and Western blot Assays)**

   1.1. Collect 10 mls. of venous blood by using disposable syringe and needle.
   1.2. Dispense 10 mls. of the venous blood into a sterile bottle and close with a screw cap and seal with a plaster strip.
   1.3. Label the specimen correctly (Name/RN) and fill the corresponding standard pathology form (Medical 135).
   1.4. Place the labelled specimen sample in a plastic bag. Label the plastic bag **"URGENT: BIOHAZARD HANDLE WITH CAUTION"**.
   1.5. Pack this plastic bag containing the specimen(s) in a suitable container to prevent breakages.
   1.6. Address and despatch with the completed Pathology Form(s) (Medical 135) to the nearest designated centres.

2. **T-Cell Enumeration Test:**

   Test for T-lymphocyte enumeration of HIV antibody positive cases should be done by prior appointment.

   2.1. Collect 15 mls. of venous blood by using disposable syringe and needle.
   2.2. Dispense 15 mls. of venous blood into the specially provided siliconised venoject tube (provided by IMR) containing preservative free sodium heparin. Close the venoject tube with the rubber stopper and seal with a plaster strip. **Gently** mix the blood. (Siliconised venoject tubes should be stored in 4°C refrigerator).
   2.3. Place the correctly labelled specimen sample in a plastic bag. Label the plastic bag **"URGENT: BIOHAZARD HANDLE WITH CAUTION."**
   2.4. Pack this plastic bag containing the specimen(s) in a suitable container **(without ice)** to prevent breakages.
   2.5. Address and despatch with the completed Pathology Form(s) (Medical 135) to reach IMR **within 6 – 12 hours.**

NOTE: STRICT CAUTION TO BE EXERCISED WHILE COLLECTING AND TRANSPORTING BLOOD SPECIMENS.

Precautions:

(1) Disposable plastic gloves are to be worn while collecting and handling blood specimens.
(2) Disposable needles and syringes are to be used and thereafter disposed of (**Appendix 17.**)

3. **Points of contact** :

HIV Antibody Test : National AIDS Reference laboratory,
Division of Virus Research,
Institute for Medical Research,
Jalan Pahang,
50588 Kuala Lumpur.
Tel: 03-2986033 Ext. 131/148/143

T-lymphocyte Test : Division of Serology & Immunology,
Institute for Medical Research,
Jalan Pahang,
50588 Kuala Lumpur.
Tel: 03-2986033 Ext. 150/157/136

Patient's consent to undergo blood test for HIV antibodies

I, _____ (Patient's name) NRIC at _____
hereby consents to the investigative procedure of the blood test for HIV antibodies of which the manner, aim and implications have been explained to me by Dr. _____ (Doctor treating) via the interpretation of _____ whom to his/her interpreter capability, had given an honest and clear interpretation of the above in the language/dialect of _____.

I hereby consent to any further investigative procedures and/or emergency treatment as may be needed or as a result of the investigation including local anaesthesia, general anaesthesia or others for any of the purposes above.

I understand that the investigative procedure may be conducted by any doctor.

I hereby confirm that a pre-test counselling has been given by _____.

Date: _____ Signature or)
Thumbprint)
of patient) _____

Before

Name: _____ Signature _____
NRIC: _____ (witness)
Post: _____

I hereby confirm that I have explained to the patient the nature and effects of the said investigative procedure.

Date: _____ Signature _____
(Doctor treating)

Patient's details:
Registration no:
Name:
Gender:
Age:
Unit:

APPENDIX 4.2

(PPDK-3 Pin.1/91)

BORANG PENDAFTARAN PENDERMA DARAH
BLOOD DONOR ENROLMENT FORM

Nama
Name (Cth: Mr Mrs Miss)

No. Kad Pengenalan
I/C No.

Alamat Rumah
Home address

Keturunan
Race

Umur
Age

Alamat Pejabat
Business address

No. telefon rumah
Home telephone No.

Pekerjaan
Occupation

No. telefon pejabat
Business telephone No.

Pernahkah anda menderma darah dahulu? Ya/Tidak
Have you ever donated blood before? *Yes/No*

Jika ada, bila
If so, when

di mana
where

Serial No.

SOALAN PERUBATAN
MEDICAL QUESTIONAIRE

Pernahkah anda menerima pemindahan darah? Ya/Tidak
Have you ever received blood before? *Yes/No*

Jika ada, bila
If so, when

Adakah anda pernah menghidap penyakit-penyakit berikut:
Have you ever suffered from the following:

Demam Kuning *Jaundice/ Hepatitis*	☐	Batuk Kering *T.B.*	☐	Darah Tinggi *High Blood Pressure*	☐
Lelah *Asthma*	☐	Penyakit Jantung *Heart Disorder*	☐	Alahan *Allergies*	☐
Gila Babi *Fits/Convulsion*	☐	Pembedahan *Any operation*	☐	Malaria *Malaria*	☐
Lain-lain penyakit *Other illness*	☐				

Saya faham bahawa saya tidak boleh menderma darah sekiranya saya seorang yang mengamalkan perhubungan sejenis (homosexual) atau perhubungan jenis dengan kedua-dua jantina (bisexual) atau penagih dadah melalui suntikan, atau melakukan perhubungan jenis dengan mereka yang di atas.

I realise that I shall not donate blood if I am a practising homosexual/bisexual or an IV drug abuser or a sexual partner of one of the above.

Saya membenarkan pengambilan darah saya setakat 450 ml dan digunakan darah ini untuk ujian VDRL, Anti-HIV, HBs Ag atau untuk tujuan-tujuan lain yang difikirkan perlu oleh pihak hospital. Saya faham bahawa semua keputusan akan dianggap sulit.

I voluntarily give permission to withdraw blood up to the amount 450 ml and to use this blood for testing for VDRL, Anti-HIV, HBs Ag in whatever manner deemed appropriate by the hospital. I understand that all results will be treated as confidential.

Tandatangan .....
Signature

Tarikh .....
Date

Unit P.N. K.L.

Appendix 4.3

PROGRAM SARINGAN ANTI-HIV DAN HBSAg

Borang Kebenaran Bertulis

Saya _____ (Nama)
Reg. No _____ K/P No _____
membenarkan secara sukarela pengambilan darah saya setakat 8ml. untuk ujian Anti-HIV, (AIDS) dan HBSAg (Hepatitis B) atau untuk tujuan-tujuan yang difikirkan perlu oleh pihak hospital/Jabatan Kesihatan Dewan Bandaraya Kuala Lumpur.

Tandatangan _____

Tarikh _____

/SP

PROGRAM SARINGAN ANTI-HIV DAN HBSAg

Borang Kebenaran Bertulis

Saya _____ (Nama)
Reg. No _____ K/P No _____
membenarkan secara sukarela pengambilan darah saya setakat 8ml. untuk ujian Anti-HIV, (AIDS) dan HBSAg (Hepatitis B) atau untuk tujuan-tujuan yang difikirkan perlu oleh pihak hospital/Jabatan Kesihatan Dewan Bandaraya Kuala Lumpur.

Tandatangan _____

Tarikh _____

/SP

APPENDIX 5.1

Chev Li Hua
d/a Fakulti Undang-Undang
59100 Kuala Lumpur

11 Mei 1992

Setiausaha
Majlis Perubatan Malaysia
d/a Kementerian Kesihatan
Jalan Cenderasari
50590 Kuala Lumpur

Tuan

Per: Penyelidikan Isu-Isu 'Medico-Legal'

Besarlah harapan saya sekiranya pihak tuan dapat merujukkan untuk saya Garispanduan Majlis Perubatan Malaysia berkenaan AIDS dan HIV.

Penyelidikan saya meliputi kesan undang-undang berkenaan HIV dan AIDS. Dilampirkan bersama-sama surat ini surat penjelasan daripada Dekan, Fakulti Undang-Undang.

Sekian, terima kasih.

Yang benar

Chev Li Hua

MAJLIS PERUBATAN MALAYSIA.
(MALAYSIAN MEDICAL COUNCIL)
KEMENTERIAN KESIHATAN MALAYSIA.
(MINISTRY OF HEALTH MALAYSIA)
JALAN CENDERASARI.
50590 KUALA LUMPUR

Telefon: 2985077
Kawat: MINHEALTH, KUALA LUMPUR
No. Faks: 2985964, 2911436

APPENDIX 5.2

Ruj. Tuan:

Ruj. Kami: (180)dlm. KKM-114/16 Jld. 10

Tarikh: 15 hb. Jun 1992.

Cik Chew Li Hua,
d/a Fakulti Undang-Undang,
Universiti Malaya,
59100 Kuala Lumpur.

Puan,

Per : Penyelidikan Isu-Isu 'Medico-Legal'

Merujuk kepada surat puan yang bertarikh 11hb Mei 1992 mengenai perkara di atas.

2. Dukacita dimaklumkan bahawa Bahagian ini tidak dapat memberi maklumat mengenai isu-isu 'medico-legal' berkenaan AIDS dan HIV sepertimana yang diminta.

3. Walau bagaimanapun, puan diminta berhubung terus dengan Kementerian Kesihatan Malaysia, Bahagian Kesihatan, Jalan Dungun, Kuala Lumpur dimana mereka mungkin mempunyai maklumat-maklumat sepertimana yang puan kehendaki.

Sekian, terima kasih.

'BERKHIDMAT UNTUK NEGARA'

(DR. NORNAH MOHD. KHALID)
Setiausaha,
Majlis Perubatan Malaysia.

NK/mah..

(Sila catatkan rujukan surat ini apabila menjawab)

GUIDELINES FOR THE SCREENING OF HIGH RISK GROUPS FOR HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION/AIDS

A. Introduction

In the local context, population groups defined as at risk to HIV infection/AIDS are the homosexuals/bisexuals, prostitutes, intravenous drug abusers, prisoners, patients with other sexually transmitted diseases (STDs), transfusion dependent patients and those with intimate sexual contact with the above.

B. Rationale

It is important that people who are infected with HIV be identified early so that they could be counselled against its spread. However, the majority of those infected do not manifest any signs or symptoms of AIDS, making early clinical diagnosis difficult or impossible. These people can only be identified by serological tests on their blood for HIV. Whole population screening is ideal but an expensive programme. Therefore, the next best option is the screening of target groups for HIV antibodies.

C. Objectives

General: To identify and screen people in the high risk groups such as homosexuals/bisexuals, prostitutes, intravenous drug abusers, patients with other sexually transmitted diseases (STDs), tuberculosis in young/middle age persons, newly diagnosed mental patients and transfusions dependent patients for HIV antibodies.

Specific:
1. To identify and register all those in the high risk groups.
2. To screen all those in the high risk groups for HIV antibodies using the ELISA test and Western blot assay if found repeatedly reactive.
3. To establish the incidence of HIV infection/AIDS in the identified high risk groups.
4. To refer to those confirmed positive to HIV for medical counselling.
5. To periodically review screening tests in terms of cost-effectiveness.

D. Organisation of screening programme

National Level:
The Technical Commitee on HIV infection of the AIDS Task Force.

State Level:
The State Co-ordinating Committee on HIV infection.

Terms of reference of the committees:

National
- To plan and coordinate the national activities in the screening of high risk groups for HIV antibodies.
- To compile state reports on the screening programme and to produce an annual report.

State
- To implement the screening programme.
- To provide quarterly report of the screening programme to the national secretariat.

E. Screening Test

The screening test is the ELISA. Refer to **(Appendix 4)**.

F. Screening programme for multiple transfusion dependent patients

(See **Appendix 12**).

G. Screening of Prisoners

i) Prisoners in all prisons in the country are to be screened for HIV antibodies. A master register of those already screened is to be maintained.

ii) Priority is to be given to those who have high risk factors such as homosexuals, bisexuals, intravenous drug abusers or prostitutes (female prisoners).

iii) Screening should be done before their release from prison. Screening is done once for each admission into a prison.

iv) A team to collect the blood samples should come from either the nearest Health Centre or Hospital. This team shall consist of:-

Medical Officer	–	1
Medical Assistant	–	1
Assistant Nurse	–	1
Attendant	–	1
Driver	–	1

v) Security arrangement and other assistance can be obtained from the local prison authority.

vi) For each blood sample, an investigation form in duplicates are filled. Example of such form is as shown in **Appendix 11.1.** A signed consent from the prisoner for the taking and testing of the blood for HIV antibody is to be obtained.

vii) The blood samples and the forms are sent to the nearest designated screening centre for ELISA test.

viii) Notification of a positive sample is done confidentially as shown in the flow chart. **(Appendix 9).**

ix) The management and follow-up of a positive WB test is similar to that of the transfusion dependent patients.

H. Screening of Intravenous Drug Abusers

a. Those in Drug Rehabilitation Centres

i) Drug addicts in all rehabilitation centres in the country are to be screened for HIV antibodies. A master register is to be maintained for all those who are screened.

ii) Screening should be done before their release from the centres and once for every admission.

iii) The team to collect the blood samples is similar to that for prisoners.

iv) Security arrangement and other assistance can be obtained from the authority of the local Drug Rehabilitation Centre. The points of contacts are in **Appendix 11.2.**

v) For each blood sample, an investigation form in duplicates are filled.

vi) The blood samples and the forms are sent to the nearest designated screening centre for ELISA test.

vii) Notification of a positive sample should be done confidentially.

b. Drug Addicts at large

i) The plan of operation should be discussed with the local Anti-narcotic section of the Police Department.

ii) Blood samples are obtained from addicts rounded up by police during their normal raids. However, no sample is to be taken if there is physical resistance. A signed consent form is necessary.

iii) A master register of those screened is to be maintained. A 3 monthly screening test is recommended. A similar team as before is required for the blood samples collection.

I. Screening of Prostitutes

a. Those in Refuge Homes

i) Prostitutes in all refuge homes in the country are to be screened for HIV antibodies, after a signed consent form is obtained.

ii) Screening should be done before their release from the homes and once for each admission.

iii) A team to collect the blood samples should come from either the nearest Health Centre or Hospital.

This team shall consists of:-

Medical Officer	–	1
Assistant Nurse	–	1
Attendant	–	1
Driver	–	1

iv) Co-ordination,arrangement and other assistance can be obtained from the local authority in-charge of the refuge home. The points of contacts are in **Appendix 11.3.**

b. Prostitutes at large

i) The plan of operation should be discussed with the local Anti-vice section of the Police Department and the Department of Social Welfare.

ii) Blood samples are obtained from the prostitutes rounded up by the police during their normal raids. However, no physical force shall be used.

iii) A similar team as before is required for the collection.

J. Screening of Homosexuals

i) The plan of operation should be discussed with the local Anti-vice section of the Police Department and the Department of Social Welfare.

ii) Blood samples are obtained from the homosexuals rounded up by police during their normal raids. (after a signed consent from is obtained)

iii) Local private medical practitioners who treat homosexuals should be encouraged to participate.

K. Screening of STDs/T.B./mental patients and High Risk Groups seeking medical treatment.

i) It is prudent to screen all STDs, tuberculosis in young/middle age and newly diagnosed mental patients as well as the high risk groups seeking medical treatment in hospital/clinics for HIV antibodies.

ii) A signed consent is **NOT** necessary.

iii) For regular STD patients, it is recommended that screening be done at 3 monthly interval.

iv) A similar master register is to be maintained by the respective clinic/ward and the blood samples are sent to the nearest designated screening centre.

L. Reporting

i) A monthly report of activities on the screening of high risk groups is to be regularly submitted to the State Co-ordinating Committee on HIV infection (SCCHI) by the first week of the following month.

ii) SCCH shall compile the data and submit to the Epidemiology Unit, every quarterly.

Index No. _____ Prison No. ☐☐☐☐☐☐

*Serological Screening Of High Risk Groups for HIV infection

Note: This form is to be filled in duplicate and to accompany the blood sample and sent to the nearest Designated Screening Centre.

1. Specimen: Date taken _____ Place taken _____

2. Name: _____ 3. I/C/Passport No: ☐☐☐☐☐☐☐☐

4. Date of Birth: Day ☐☐ Mth ☐☐ Yr ☐☐ 6. Sex: Male ☐ Female ☐ Other ☐ 7. Race: Malay ☐ Chinese ☐ Indian ☐ Other ☐ specify _____

5. Age: ☐☐ Years

8. Nationality: Malaysian ☐ Others ☐ specify _____

9. Usual Home Address _____ Tel: _____

10. Present Address (if different from 9) _____ Tel: _____

11. Present Occupation: _____ 12. Employer: _____

13. Address of work place: _____ Tel: _____

14. Offence Committed (if applicable) _____

15. Risk Group: Homosexual ☐ Bisexual ☐ Transvestite ☐ Prostitute ☐ iv drug user ☐ Prisoner ☐ STD Patient ☐ Others ☐ specify _____

Doctor's Name (Block Letters) _____ Initial _____

Date: _____

For Laboratory Use Only:

1. Screening Centre: _____ RN: ☐☐☐

2. Date specimen received: Day ☐☐ Mth ☐☐ Yr ☐☐

3. Tests:

	Date	Test Methods	Result	Note
3.1				
3.2				
3.3				

4. Notification: Telephone ☐ Despatch ☐ Day ☐☐ ☐☐ Mth ☐☐ ☐☐ Yr ☐☐ ☐☐

Name of Officer (Block Letters) _____ Initial _____

Date: _____

Appendix 7

Definition of "factory" under the Factories and Machinery Act 1967

2. Interpretation of "factory"

(1) In this Act unless the context otherwise requires, "factory" means any premises or part of a premises where -

(a) within the close or curtilage or precincts of the premises or part thereof persons are employed in manual labour in any process for or connected with or incidental to the making, altering, repairing, ornamenting, sorting, finishing, cleaning, washing, breaking, demolishing, constructing, re-constructing, fitting, refitting, adjusting or adapting of any article or part thereof; and

(b) the said work is carried on by way of trade for the purposes of gain or incidentally to any business so carried on,

and (whether or not they are factories by reason of the foregoing definition) the expression factory also includes the following premises in which persons are employed in manual labour:

(i) any yard or dry dock (including the precincts thereof) in which ships or vessels are constructed, re-constructed, repaired, refitted, finished or broken up;

(ii) any premises in which the business of washing or filling bottles or containers or packing articles is carried on incidentally to the purposes of any factory;

(iii) any premises in which the business of hooking, plaiting, lapping, making-up or packing of yarn or cloth is carried on;

(iv) any laundry carried on as ancillary to another business or incidentally to the purposes of any public institution;

(v) any premises in which the construction, reconstruction, or repair of locomotives, vehicles or other plant for use for transport purposes is carried on ancillary to a transport undertaking or other industrial or commercial undertaking;

(vi) any premises in which printing by letter press, lithography, photogravure, or other similar process, or bookbinding is carried on by way of trade or for purposes of gain or incidentally to another business so carried on;

(vii) any premises in which the production of cinematograph films is carried on by way of trade or for purposes of gain;

(viii) any premises in which manual labour is employed and mechanical power is used in connection with the making or repair of any article of metal or wood incidentally to any business carried on by way of trade or for purposes of gain;

(ix) any premises used for the storage of gas in a gasholder having a storage capacity of not less than 5,000 cubic feet;

(x) any premises, place or space where any building operations or works of engineering construction are carried out; and

(xi) any premises belonging to or in the occupation of the Federal Government or the Government of any State or of any local authority or other public authority which would be a factory within the meaning of this Act but for paragraph (b),

but does not include -

(i) any premises used for the purposes of housing locomotives or vehicles where only cleaning, washing, running repairs or minor adjustments are carried out; or

(ii) any premises where five or less persons carry on any work in which machinery is not used notwithstanding that the premises, by virtue of the work, would constitute a factory within the meaning of this section.

(2) Any line or siding which is used in connection with and for the purposes of a factory, shall be deemed to be part of the factory.

Appendix 8

S 10 of the Factories and Machinery Act 1967

10. Provisions relating to safety, etc.

Without prejudice to any law with respect to local authorities, in respect of any factory, the following provisions relating to safety shall apply:

(a) foundations and floors shall be of sufficient strength to sustain the loads for which they are designed; and no foundation or floor shall be overloaded;

(b) roofs shall be of sufficient strength to carry where necessary suspended loads;

(c) all floors, working levels, platforms, decks, stairways, passages, gangways, ladders and steps shall be of safe construction so as to prevent a risk of persons falling, and structurally sound so as to prevent a risk of collapse, and shall be properly maintained and kept, as far as reasonably practicable, free from any loose material and in a non-slippery condition;

(d) such means as are reasonably practicable shall be provided, maintained, and used so as to ensure safe access to any place at which any person has at any time to work;

(e) every opening, sump, pit or fixed vessel in a floor, or working level shall be securely covered or securely fenced so as to prevent risk of persons falling; and

(f) all goods, articles and substances which are stored or stacked shall be so placed or stacked -

(a) in such manner as will best ensure stability and prevent any collapse of the goods, articles or substances or their supports; and

(b) in such a manner as not to interfere with the adequate distribution of light, adequate ventilation, proper operation of machinery, the unobstructed use of passageways or gangways and the efficient functioning or use of fire-fighting equipment.

Section 22 of the Factories and Machinery Act 1967

22. Provisions relating to health

(1) Without prejudice to any law relating to public health, in respect of any factory the following provisions relating to health of persons shall apply:

(a) every factory shall be kept in a clean state and free from offensive effluvia arising from any drain, sanitary convenience or other source and shall be cleaned at such times and by such methods as may be prescribed and these methods may include lime-washing or colour washing, painting, varnishing, disinfecting or de-odorising;

(b) the maximum number of persons employed at any one time in any work-room in any factory shall be such that the amount of cubic feet of space and the superficial feet of floor area allowed in the work-room for each such person are not less than the amount of cubic feet of space and the superficial feet of floor area prescribed either generally or for the particular class of work carried on in the work-room;

(c) (i) effective and suitable provision shall be made for securing and maintaining adequate ventilation by the circulation of fresh air in every part of a factory and for rendering harmless, so far as practicable, all gases, fumes, dust and other impurities that may be injurious to health arising in the course of any process or work carried on in a factory;

(ii) the Minister may prescribe a standard of adequate ventilation and the means by which the standard may be achieved, for factories or for any class or description of factory or parts thereof;

(d) (i) effective and suitable provision shall be made for securing and maintaining such temperature as will ensure to any person employed in a factory reasonable conditions of comfort and prevention from bodily injury;

(ii) the Minister may for factories or for any class of factory or parts thereof prescribe a standard of reasonable temperature and prohibit the use of any methods of maintaining a reasonable temperature which in his opinion are likely to be injurious to the persons employed and direct that thermometers shall be provided and maintained in such places and positions as may be specified;

(e) (i) effective provision shall be made for securing and maintaining sufficient and suitable lighting, whether natural or artificial, in every part of a factory in which persons are working or passing;

(ii) the Minister may prescribe a standard of sufficient and suitable lighting for factories or for any class or description of factory or parts thereof or for any process; and

(f) sufficient and suitable sanitary conveniences as may be prescribed, shall be provided and maintained for the use of persons in a factory.

(2) (a) Whenever it appears to an Inspector that any process in any factory is likely to affect adversely the health of any person employed therein or the public he shall report the circumstances in writing to the Chief Insepctor who may thereupon carry out such investigations as he may consider necessary.

(b) Where the Chief Inspector is satisfied -

(i) that such a process is likely to affect adversely the health of any person employed in the factory or the public; and

(ii) that the process can be modified or means provided to reduce the possibility of injury to the health of such person or the public as aforesaid.

he shall, after considering any representations made by the occupier of the factory, order that the process be modified in such manner or that such means be provided as he may direct to reduce the possibility of injury to the health of that person or the public.

(c) Any person aggrieved by an order made under paragraph (b) may within twenty-one days of the receipt thereof appeal to the Minister who shall make such order thereon as he deems fit.

(d) Where the Chief Inspector is satisfied -

(i) that such a process is likely to affect adversely the health of any person employed in the factory or the public; and

(ii) that the process cannot be modified or means provided to reduce the possibility of injury to the health of such person or the public as aforesaid,

he shall report the circumstances in writing to the Minister.

(e) The Minister may upon receipt of the report either -

(i) make such regulations controlling or prohibiting the use of the process as he may consider reasonable; or

(ii) after considering any representations made by any person likely to be affected thereby by writing under his hand prohibit the carrying out of the process either absolutely or conditionally or the use of any material or substance in connection therewith.

(f) For the purpose of enabling any occupier of a factory or other person to make representations in respect of a proposed order or prohibition under paragraph (b) or (e) the Chief Inspector or the Minister as the case may be, shall cause to be served on the occupier or other person a

notice specifying the period within which such representations may be made and containing such particulars as the Chief Inspector or the Minister as the case may be considers adequate in the circumstances.

(3) An Inspector may require any person employed in any factory in which any of the diseases named in the Third Schedule has occurred, or is likely to occur, to be medically examined.

THIRD SCHEDULE

NOTIFIABLE INDUSTRIAL DISEASES
(Section 32 of Factories and Machinery Act 1967)

1. Dust diseases of the lungs:

   (a) Silicosis - inhalation of (SiO_2) silica containing dust.

   (b) Stannosis - inhalation of tin dusts or fumes.

   (c) Siderosis or sidero-silicosis inhalation of dust containing iron and silica, haematite.

   (d) Asbestosis - inhalation of asbestos dust or fibres.

   (e) Conditions of respiratory allergy of asthma or chronic bronchitis, or byssinosis resulting from inhalation of dusts of plant origin as cotton, wood, flax, jute, rice husks, cork, spices, hemp, sisal, tobacco, tea, flour and the like and mineral dusts as cements, copper, zinc, or animal dusts as bone or hair.

   (f) Other pneumoconioses or fibrotic diseases of the lungs resulting from inhalation of aluminium or talc, or coal.

2. Systematic intoxication by any of the following metals or their compounds, lead, mercury, manganese, phosphorous, antimony, chromium, nickel, beryllium.

3. Intoxication resulting from the use of solvents as benzene and other aromatic hydrocarbons, carbon disulphide, chlorinated hydrocarbons, and petroleum and its derivatives.

4. Pulmonary irritation resulting from inhalation of nitrogen oxides, sulphur oxides, chlorine, phosgene, ammonia, etc.

5. Intoxication resulting from handling of insecticides, or herbicides or fungicides or organic phosphate compounds, nitrogenous and chlorinated compounds.

6. Conditions or occupational dermatosis resulting from handling of mineral oils, acids, alkalis, dusts, and other irritants.

7. Occupational infections as anthrax, glanders, and leptospirosis, tuberculosis, leprosy (where occupational exposure to the last two is evident).

8. Malignant disease resulting from handling or inhalation or contact with carcinogenic tars, or radioactive dusts.

9. Eye conditions resulting from physical trauma as heat cataract, radiation cataract and from irritants.

10. Toxic jaundice resulting from nitro or amino derivatives of benzene or other substances.

11. Subcutaneous or acute bursitis of knee or hand or wrist resulting from manual labour causing severe or prolonged friction or pressure.

12. Conditions resulting from severe heat exposure such as heat cramps or heat stroke.

13. Hearing loss due to excessive exposure to industrial noise of high sound pressure level.

14. Conditions resulting from exposure to ionizing and non-ionizing radiation.

15. Decompression sickness (caisson disease) and conditions resulting from working under water.

Factories and Machinery Act 1967

32. Notification of industrial diseases

Every registered medical practitioner attending on, or called in to visit, a patient whom he believes to be suffering from any of the diseases named in the Third Schedule and contracted in a factory shall, unless such notice has been previously sent -

(a) forthwith send to the Chief Inspector a notice stating the name and location of the factory in which the patient states he is or was last employed, the name and full postal address of the patient and the disease from which, in the opinion of the registered medical practitioner, the patient is suffering; and

(b) at the same time send a copy of the notice to the occupier of the factory in which the patient states he is or was last employed.

/SULIT/

BORANG PENYIASATAN AIDS

Epid 101

Regist. No.
(leave blank)

Notes

Please read carefully
before filling the forms

1. NAME (in block letters)

2. HOSPITAL/CLINIC REGISTRATION NO.
(1 – 7)

3. I.C./B.C./PASSPORT NO. (Delete/Which is not applicable)
(8 – 15)

4. SEX: (16) MALE ☐
FEMALE ☐

5. DATE OF BIRTH: AGE IN YEARS (17 – 18)
Day Mth Yr

6. Place of birth: _____

7. MARITAL STATUS: (19)
Married ☐ Single ☐ Divorced ☐
Separated ☐ Widowed ☐ Unknown ☐

8. ETHNIC GROUP: (20) Malay ☐ Chinese ☐ Indian ☐ Others ☐ _____ (specify)

9. PRESENT OCCUPATION:

10. ADDRESS OF WORK PLACE:
Tel _____

11. USUAL RESIDENTIAL ADDRESS:

12. PRESENT ADDRESS IF DIFFERENT FROM 11:
Tel _____

13. FAMILY HISTORY
Attach information on the age, sex, occupation and health status of family members (parents, siblings, wife and children).

14. Past/Present Medical History:

15. RISK FACTORS:

Homosexual ☐ Bisexual ☐ Intravenous Drug User ☐

Unknown ☐ Heterosexual Contact ☐ Haemophilia ☐

Recepients of blood transfusion/products ☐ Others ☐

(specify) _____

16. RECENT SEXUAL CONTACTS: YES ☐ NO ☐

If yes, name of contacts: _____ Male/Female Address:

_____ Male/Female

_____ Male/Female

17. HAS PATIENT:

(a) donated blood – YES ☐ NO ☐ ☐☐☐☐☐☐

If yes, where _____ When Day Mth Yr

(b) received blood – YES ☐ NO ☐ ☐☐☐☐☐☐

If yes, where _____ When Day Mth Yr

(c) received I.V. drugs – YES ☐ NO ☐ ☐☐☐☐☐☐

If yes, where _____ When Day Mth Yr

(d) visited a foreign country – YES ☐ NO ☐ ☐☐☐☐☐☐

If yes, where _____ When Day Mth Yr

(specify COUNTRY/STATE)

18. CLINICAL FINDINGS

a. ARC Case Report (AIDS Related Complex Signs/Symptoms)

(Check all signs/symptoms persistent at least three month before onset of a specific infection/disease suggestive of AIDS).

Chronic lymphadenopathy ☐ Fever > 38° ☐ Skin manifestations ☐
> 3 Non contiguous (Seborrhic Dermatitis)

Weight loss > 10% ☐ Diarrhoea ☐ Buccal mucosa area ☐
Normal body weight hairy leukoplakia

Fatigue/Malaise ☐ Thrombocytopenia ☐ Others ☐
(<100,000/ mm (specify) _____

Date of Diagnosis of 1st ARC Sign/Symptom ☐☐☐☐☐☐
Day Mth Yr

b. AIDS Case Report (Medical Conditions Indicative of AIDS)

Kaposi's Sarcoma ☐ Cryptosporidiosis with diarrhoea > 1 month ☐

Pneumocystis Carinii pneumonia ☐ Candida oesophagitis ☐

Toxoplasmosis ☐ Cryptococcal infection other than pulmonary ☐

Disseminated cytomegalovirus infection ☐ Primary Lymphoma of the brain ☐

Herpes simplex infection ulceration > 1 month ☐ Atypical mycobacterial infection disseminated ☐

Progressive multifocal leukoencephalopathy ☐ Other opportunistic infections and cancers ☐

please specify _____

Date of diagnosis of 1st Medical Condition Indicative of AIDS ☐☐☐☐☐☐
Day Mth Yr

19. LABORATORY DATA:

Hb (gm%) _____ L N E B M (%) ☐☐☐☐☐ Differential count _____ Platelet count _____

TW _____

Radiologcal Report: _____

Mantoux Test: ☐ Positive ☐ Negative

Other tests (specify) _____

20. METHOD OF DIAGNOSIS:

Clinical ☐ Autopsy ☐

Histology ☐ Virology ☐

Cytology ☐ Serology: ELISA ☐

W.B. ☐

Endoscopy ☐ T-cell enumeration test ☐

ELISA (Antigen test) ☐

Others ☐ _____ (specify)

21. DESTINATION OF PATIENT:

Outpatient ☐ Hospitalised ☐ Dead ☐ When ☐☐ Day ☐☐ Mth ☐☐ Yr

Referred ☐ _____ (place referred to)

Unknown ☐

INVESTIGATING DOCTOR'S NAME: _____ SIGNATURE: _____

DESIGNATION: _____

NAME OF CLINIC/HOSPITAL: _____

DATE: ☐☐ Day ☐☐ Mth ☐☐ Yr

Appendix 12

Model Living Will

To my family, physician, lawyer and any hospital in whose care I am placed.

I, _____ of _____ hereby make the following statements of my own volition at a time when I am of sound mind and after careful consideration.

I hereby declare that I wish to participate in decisions governing my own medical care as long as possible.

However, in the event of my becoming legally incompetent or otherwise unable to refuse treatment with no reasonable expectation of ever regaining competency, the following directions express my competently made decisions and shall take effect.

I hereby authorise the withholding or withdrawal of life-sustaining procedure where my physician and one other consulting physician determines that my death is imminent with no reasonable medical expectation of recovery, whether or not such procedures are utilised.