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The Hon Justice Michael Kirby*

Do you remember the first time you heard about AIDS? For me, it was the media reports, in the early 1980s, suggesting the discovery of a new "gay cancer" on both sides of the United States. Writers theorised that it was somehow connected with the use of "poppers" (amyl nitrate) - popular at dance parties. The first reports in the medical literature came at the close of 1981.[1] Two years later, Dr Luc Montagnier of the Pasteur Institute in Paris announced that he had isolated the cause of AIDS. In April 1984 Montagnier declared that it was a virus. That virus, the human immuno-deficiency virus (HIV) soon became the target of tests to identify its presence in the body. A reliable, mass produced, test was available by March 1985. Applied throughout the world, it has revealed a global epidemic of terrible proportions. The AIDS epidemic causes fearful suffering among millions of ordinary people in every continent. Estimates vary, but the World Health Organisation suspects that up to 10 million people are already infected. The impact on sub-Saharan Africa is extremely serious. It will become devastating. The virus is now loose in the huge population centres of Asia. In western countries, such as Britain, the United States and Australia, HIV has attacked populations already vulnerable to discrimination and legal disadvantage: homosexual and bisexual men, injecting drug users and sex workers. It is this feature of this epidemic that makes it specially relevant to lawyers and law-makers.

In 1985 I delivered an address in Melbourne on some of the legal implications of AIDS. It was published in the *Australian Law Journal*.[2] It became the subject of mirth in some professional quarters: the cloistered audiences of the Bar laughing at jests about "judicial advice" on AIDS prevention. A particularly intelligent judge told me that it was inappropriate, in his view, for judges to be writing about condoms and anal sex.

Yet the dimension of the challenge of AIDS was so great, and the burden of suffering on individuals (some of them lawyers and some of them friends) was so urgent that I declined to become well mannered. A period of service on the WHO Global Commission on AIDS encouraged my interest. Now, there are whole libraries of books on the legal and human rights implications of the epidemic. Cases present the courts with complex problems. Serious policy questions confront the law-maker, struggling to balance respect for individual rights and protection of the community. Many laws have been changed in the face of AIDS. Fundamental legal strategies (such as the "war on drugs") have had to be reconsidered as the greater peril of HIV takes priority over the legal discouragement of injecting drug use. These are the reasons why judges and lawyers today, in Britain, Australia and everywhere, must be concerned about AIDS and knowledgeable about its legal implications.

In the early stages of the AIDS epidemic there were numerous calls for the quarantine of those infected with HIV. Once the test for the presence of HIV was confirmed, demands were made for universal testing of the population, like that used forty years ago in the campaign to eradicate tuberculosis.[3] Public health legislation provided the means of enforcing quarantine. But, gradually, it became clear that this was not a feasible option. The test to the antibodies would mask a period of infection known as the "window period". This might be up to three months. The infected person would have, on average, a decade or more of economic productivity before succumbing to end stage AIDS. The flood of tourists could not be tested without a serious impact on a major earner of foreign exchange. Quarantine exists in Cuba. It was tried in Romania. But elsewhere, different legal strategies have been chosen.

Some enhancement of official powers of detention has accompanied the epidemic.[4] But the powers are rarely used and are relatively insignificant in the overall response.

The time may come when we have a vaccine and a cure for AIDS. Vaccines seem more promising than cures. But until we do, behaviour modification is our best strategy. That is why most Western communities have concentrated on winning the attention and trust of vulnerable groups whose risky behaviour may expose them to infection with HIV. In Australia, this has meant:

* Repeal in all States (except Tasmania) of criminal laws which punish consensual adult homosexual conduct;
* Adoption of needle and syringe exchange programmes to reduce the risk of spread of HIV amongst injecting drug users who share equipment. These programmes coincide with the "war on drugs". The statutory provisions prohibiting possession of equipment for the administration of drugs remain on the books;
* Attempts to reform laws governing prostitution and to reduce official interference in the consensual activities of the sex industry and of individual sex workers; and
* Regulations and unofficial policies to permit the availability of condoms and cleaning bleach in prisons to prevent prisons becoming incubators of the virus as has happened in some countries.

The responses along these lines has been uneven because generally regulated by State laws in Australia. But with Federal leadership, and a wide measure of support from the major political parties, the strategy has helped to lower the spread of infection. Notably, the incidence of sero-conversions to HIV amongst young gay men has dropped. The incidence of infections amongst injecting drug users, sex workers and prisoners is low. The supportive strategy of behaviour modification, reinforced by law reform, has produced results in the saving of lives. These results have been

reinforced by the passage of anti-discrimination laws. Every jurisdiction in Australia (except Tasmania and the Northern Territory) has laws which protect people from unwarranted discrimination on the grounds of HIV or AIDS. These set community standards. In a number of jurisdictions, discrimination on the grounds of sexual orientation is also prohibited. These laws have not prevented particular problems arising:

* In the practices of insurers in relation to the provision of insurance and superannuation;
* In the prevention of publicity of the HIV status of public persons unwilling to reveal their private affairs; and
* In the reform of the law of guardianship, the extension of the "family" for family provision purposes and the enlargement of the scope of legislation on *de facto* relations for the protection of partners of people struck down by AIDS..

In the courts, much of the litigation in Australia to date has concerned claims arising out of the contaminated blood supply in the early years of AIDS. At the recent Australian Legal Convention in Hobart, a major session was devoted to "HIV litigation in Australia".[5] The irony of this development, in less than a decade since my first, much criticised, paper, was not lost on me. The paper, written by a solicitor involved in many cases, reveals that a very large number of actions have been commenced since 1989 on behalf of haemophiliac citizens, reliant for their survival on a safe blood supply. One of the earliest cases arose in 1984 when a patient sought access to the identity of the blood donor who, he suspected, might have occasioned his infection. Access was refused.[6] Unfortunately, Australia had the highest rate of transfusion-associated AIDS, doubtless because of the centralisation of the supply of blood products. Other cases have been brought concerning alleged negligence in the use of blood at operation where, it is claimed, reasonable care and available knowledge would have produced higher standards of HIV protection for the patient.[7]

Many cases have concerned arid questions of choice of jurisdiction within Australia - an issue made relevant by differing limitation laws. Many other cases have concerned the application of Federal legislation imposing duties of merchantable quality upon suppliers of goods.[8] And still, the cases concerning the disclosure of the identity of blood donors come up for determination.[9] The large number of people with common problems has presented a challenge to the courts to find better procedures for representative actions.

The foregoing is but the briefest indication of some of the challenge which the advent of HIV has presented to the law. Like a thief in the night, this unexpected pandemic has crept upon us. Many lawyers and many friends will suffer before we are through and AIDS is committed to a footnote to history. On the journey to that time, there will be many problems for lawyers: big policy decisions on the shape of the law and much litigation involving individual cases. And for once, the law can play a constructive rôle in supporting behaviour modification which is still the best protection from HIV. And a compassionate rôle to prevent unjust discrimination and to redress wrongs where they occur. Judges and lawyers should base their decisions about HIV/AIDS upon a realistic understanding of human behaviour - without prejudice, discrimination and stereotypes. Perhaps in confronting AIDS we will also respond more boldly and honestly to other issues which confront our societies and their laws and which concern human sexuality and drug use.

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1. See eg *The Lancet*, 12 December 1981 (Editorial Note).
2. (1986) 60 *Australian Law Journal* 324.
3. See eg *Public Health Act* 1902 (NSW), s 29A.

4. See eg *Public Health (Control of Disease) Act* 1984 (UK).

5. P Gordon, "HIV Litigation in Australia" in Papers, 28th Australian Legal Convention, Hobart, September 1993, p 179.

6. *Loker v St Vincent's Hospital (Darlinghurst) and Anor*, Supreme Court (NSW), unreported, 11 October 1985.

7. *H v The Royal Alexandra Hospital for Children & Ors* [1992] *Aust Torts Rep.* 81-000, 67, 503; *"E" v Australian Red Cross Society & Ors* [1991] *Aust Trade Prac Rep* 41-085, 52, 327 (FC).

8. *Nelson v Concrete Constructions (NSW) Pty Limited* [1989] *Aust Trade Practices* 40-936, 50, 170 (FC).

9. *PD v The Australian Red Cross Society (New South Wales Division) & Anor* [1993] *Aust Torts Rep* 81-205, 62, 013.