BT

v.

Oei

IN THE SUPREME COURT OF NEW SOUTH WALES
COMMON LAW DIVISION

5 November 1999
[1999] NSWSC 1082

PARTIES:
BT as Administratrix of the Estate of the Late AT (First Plaintiff)
BT (Second Plaintiff)
Dr Michael Oei (Defendant)

COUNSEL:
Mr P Menzies QC/Ms L Whalan (Plaintiffs)
Mr P Garling SC/Ms J Lonergan (Defendant)

SOLICITORS:
Maurice Blackburn Cashman (Plaintiffs)
Tress Cocks & Maddox (Defendant)

BELL J

Friday, 5 November 1999

020143/95 - BT as Administratrix of the Estate of the Late AT & Anor v Oei

JUDGMENT

1 HER HONOUR: These proceedings were commenced pursuant to an order made by Ireland J on 24 February 1995 permitting the plaintiffs to be identified by the pseudonyms "AT" and "BT". AT died on 26 February 1995. Thereafter BT, in her capacity as administratrix of the estate of AT, continued the proceedings both on her own behalf and on behalf of the estate of AT.

2 The defendant is a medical practitioner in general practice in the inner city of Sydney. AT was his patient. The two claims seek damages for personal injuries arising out of the defendant's alleged negligent failure to diagnose AT's HIV illness and to counsel him (adequately or at all) to undergo an HIV antibody test. It is contended that a general practitioner, in practice in Sydney in 1992, exercising ordinary care and skill would have identified that AT was at risk of having contracted HIV in the light of his history and

symptoms. In the event, AT did prove to be HIV positive. BT who was living with AT as his de facto wife (they subsequently married) also contracted HIV.

3 The claim made on behalf of the estate of AT is for general damages for psychiatric injury and/or nervous shock suffered by AT upon learning that he had infected his wife with HIV. It is common ground that the defendant owed a duty of care to his patient, AT.

4 The plaintiff's personal claim requires consideration of whether the defendant, in addition to the duty to his patient, also owed a duty of care to her as his patient's sexual partner.

Factual Background

The Consultations

5 AT consulted the defendant for the first time on 26 November 1991. He was complaining of a sore throat, fever and a cough. The defendant obtained a history that AT did not suffer from allergies. He was a separated man working as a building contractor who described himself as a non-smoker and social drinker. On examination, the defendant observed lymphadenopathy (swollen glands). He made a provisional diagnosis of viral laryngotrachitis and pharyngitis.

6 AT next saw the defendant on 28 January 1992. He complained of fever, urinary symptoms, bilateral abdominal pain and lethargy. The defendant observed that AT had a coated tongue, lymphadenopathy, generalised tenderness of the abdomen with a palpable hepatomegaly. He made a provisional diagnosis of appendicitis or Hepatitis and arranged for AT to undergo a range of tests including a full blood count, liver function test and Hepatitis screen. AT was advised to return the following day.

7 On 29 January 1992, AT returned for a further consultation as directed. He was still unwell and feverish. By that time the defendant had the results of a test which confirmed a provisional diagnosis of urinary tract infection. The defendant prescribed Augmentin Forte and instructed AT to return when the results of the other tests were available.

8 AT next saw the defendant on 1 February 1992. He complained of feeling very tired and depressed. The liver function test was suggestive of Hepatitis B. The defendant considered that the combination of Hepatitis B and a urinary tract infection was unusual. It was unusual for a male to develop a urinary tract infection. In evidence the defendant said that urinary tract infections in males may be associated with anal intercourse. During this consultation the defendant questioned AT about his sexual activities; whether he was homosexual or bisexual or had numerous sexual partners. He also asked if AT was an intravenous drug user. AT denied any history in this regard but he referred to "casual exploits" as a possible source of the Hepatitis B infection.

9 The defendant says that at the consultation of 1 February he told AT that the Hepatitis B infection could have been acquired as the result of an unprotected sexual encounter and he gave AT three pamphlets, two concerning Hepatitis B and a third relating to safe sex practices, and counselled him in relation to safe sex practices. He recalled AT brushing this off with the comment that he would have "no energy for it".

10 The consultation on 1 February 1992 concluded with the defendant advising AT to rest. He gave him a medical certificate for one week. He ordered further tests and advised AT to return in due course to obtain the result of them.

11 The defendant next saw AT on 10 February 1992 when AT said that he was feeling a little better. A test result suggested the presence of a phlebolith (kidney stone). AT was concerned about the phlebolith and requested referral for its removal. The defendant was of the view that it was not a matter for concern and so advised AT. He recommended further rest and instructed AT to return for review in two weeks time.

12 AT returned on 4 March 1992. On this occasion AT reported that he had been feverish and suffering chills, aches and pains. He was given a medical certificate for two weeks and asked to return for further review. He did so on 19 March 1992. On that occasion he indicated that he was feeling much better. The defendant ordered a repeat full blood count, liver function test and other tests.

13 AT next saw the defendant on 1 December 1992. On this occasion he again presented complaining of fever and aches and pains. He described himself as being very irritable and suffering from a mild headache. The defendant made a provisional diagnosis of viral illness. He ordered a full blood count and further tests.

14 The defendant next saw AT on 15 January 1993 when he was complaining of bilateral ringing of the ears, feeling unwell with left sided abdominal pain and constipation. The defendant carried out a physical examination which revealed abdominal tenderness and bilateral ear wax. On this occasion he arranged for AT to undergo a barium enema.

15 AT returned to see the defendant on 22 January 1993 and reported that he was feeling a little better. He had undergone a barium enema in the meantime and the results of that procedure revealed spleenomegaly. He was referred for a CAT scan to investigate this more fully. On 30 January 1993 he again saw the defendant. The CAT scan result revealed heptospleenomegaly suggestive of cirrhosis of the liver. The defendant considered that AT required further investigation and referred him to Dr Bill Bye, Gastroenterologist, for further management. This was the last occasion on which the defendant saw AT.

The relationship between AT and BT

16 BT met AT around March 1992. It appears that their introduction arose in consequence of one or other of them placing an advertisement in a newspaper. AT collected BT from her home and they went to a nearby coffee shop. They chatted for more than an hour. In the course of this initial discussion AT disclosed that he had contracted Hepatitis B. He told BT that he was better now and that he did not require medication. It was necessary for him to drink a lot of fluid and rest. He also disclosed that, following his separation from his first wife, he had visited a brothel in company with a friend. He said he had had sexual relations with a young Thai girl who was an illegal immigrant. Following the discussion in the coffee shop the two went to a park and talked further. They spoke about the reasons for the breakdown of AT's marriage.

17 At the initial meeting AT and BT arranged to meet again. Thereafter there were a number of outings. AT would call to BT's home and escort her out to dinner or a club. He took her

home on each occasion. There were no sexual relations between the two. On one occasion AT attended a barbecue at BT's home.

18 Following the barbecue AT called on BT and told her that he had decided he did not wish to continue seeing her. He explained that he did not believe he could manage a relationship with a woman who had a young child. BT was the mother of a son then aged about six or seven years. However, despite this hesitation, AT subsequently arranged to take BT out again.

19 At Easter 1992, AT and BT went on a holiday to Young. On the first day of that trip BT asked AT how he was feeling. He told her that he was tired and that he had had a slight fever that day. The following day for the first time the two had sexual intercourse. BT said that they had used a condom on this occasion because AT expressed concerns about her becoming pregnant.

20 In June 1992, BT started working in the food services department of a hospital. Between Easter and June of 1992, when she commenced employment with the hospital, the two had sexual intercourse on about three or four occasions. On those occasions they did not use a condom. BT had received a prescription for a contraceptive pill in February of 1992. At that time she was suffering menstrual problems and the prescription of the pill was apparently to settle these difficulties and not for contraceptive purposes.

21 On 9 June 1992, BT consulted her doctor, Dr Subbamma. During that consultation it appears that she told Dr Subbamma that her partner had Hepatitis B. Dr Subbamma noted: "Wishes to have Hep B test (partner has Hep B)". BT saw Dr Subbamma on a number of occasions in June and July of 1992. Dr Subbamma advised BT to undergo a course of vaccinations to immunise her against Hepatitis B. BT underwent a course of vaccinations between 7 July 1992 and 21 January 1993. BT was advised that she and AT should use condoms until she had completed the full course.

22 In September 1992, BT and AT commenced living together as de facto partners. It appears clear that on occasions, both before and after September 1992, the couple had unprotected sexual intercourse.

23 On an occasion BT accompanied AT when he saw the defendant at his rooms. BT remained throughout the consultation. AT was complaining of a sensation of ringing in the ears. She was present while the defendant syringed AT's ears. It was BT's recollection that that consultation occurred on an occasion prior to AT's trip to Japan which took place in December 1992 (T.170). In cross-examination she agreed that the only complaint so far as she was aware that AT made to the defendant was about ringing in his ears on this occasion but she went on to say "but got some more problems like stomach pain" (T.160). The defendant's notes show only one occasion when AT presented complaining of ringing in the ears. This was on 15 January 1993. He also complained of left sided abdominal pain/constipation on that occasion. I consider that BT was mistaken in her recollection that the consultation took place prior to AT's trip to Japan in December 1992. I find that she was present with AT at his consultation with the defendant on 15 January 1993.

24 In February 1993, BT became ill. She had a very severe headache and was not able to move her jaw freely. Her arms and legs were very weak. She had a high temperature and watery eyes and her throat was very sore. She was unable to eat. She attended Dr Salgo on 22

February 1993. She complained of fever and sore throat for a few days. On examination Dr Salgo noted she was very febrile. He queried whether she may have tonsillitis. He prescribed amoxicillin, paracetamol and fluids. For the reasons set out below it is probable that this was BT's seroconversion illness. In that light of that finding, and having regard to the expert evidence as to the interval between infection and the onset of a seroconversion illness (outlined at para 149 below) I consider that BT contracted HIV on or after 21 January 1993.

25 In January 1994, AT and BT quarrelled. They separated for a time following this quarrel. On 15 February 1994, BT consulted Dr Subbamma. At that time she was upset and weepy and spoke of her separation from AT. Dr Subbamma arranged for blood tests including an HIV antibody test.

26 On or about 8 March 1994, BT was advised that her HIV test was antibody positive. She was referred for counselling to the Albion Street Clinic. She followed up on this referral.

27 BT attributed her HIV positive status to sexual contact with AT. The couple had planned to marry in April 1994. When BT learned that she had contracted the disease she did not inform AT. She was concerned that he might not marry her if he was aware that she had HIV. She was worried about her own financial security and that of her son. She blamed AT for placing her in the predicament in which she found herself.

28 In October 1994 it appears that Dr Koorey, a specialist who was then treating AT for his liver condition, arranged for him to undergo an HIV test. On 24 November 1994, AT was diagnosed as HIV positive.

29 On learning of his positive status, AT expressed concern for his wife and suggested that she go to the hospital to undergo a test herself. She said she did not wish to be tested at the hospital because she had worked there. It appears that thereafter AT took her to see Dr Salgo and a further HIV test was conducted. On 9 January 1995, BT was informed by Dr Salgo that she was HIV positive. At no time did she tell either AT or Dr Salgo that she had already been made aware of her HIV positive status.

30 AT was admitted to Royal Prince Alfred Hospital in February of 1995 for a liver transplant. He died on 26 February 1995 of liver failure. He did not die in consequence of HIV or AIDS.

AT's Evidence

31 Evidence was taken from AT before a court-appointed examiner, Mr Tobin QC on 24 February 1995. In those proceedings he adhered to the contents of an affidavit which he had sworn the previous evening. In the affidavit AT stated that at no time during his treatment by the defendant was he informed that Hepatitis B was something which he might transmit to others through unprotected sexual intercourse. He said that he was given no information regarding any risks that he posed to others in that regard. He said that at no time during his treatment by the defendant was he advised to have an HIV antibody test.

32 Objection was taken at trial to the reception of the evidence of AT. I determined to admit the evidence and gave my reasons during the course of the hearing. It is appropriate in these reasons to set out something of the history of the evidence given by AT.

33 The affidavit sworn by AT was prepared by his solicitor, Mr Hirsch. Mr Hirsch first took instructions from AT on 23 January 1995 at a time when AT appeared to be in relatively good health. On the night of 22 February 1995 Mr Hirsch was advised by BT of AT's admission to hospital. Around 5 pm on 23 February 1995 Mr Hirsch spoke with Dr Adelstein and was advised that AT was in renal failure with a life expectancy of 24 to 48 hours, 72 at the most. Mr Hirsch proceeded to prepare the affidavit for execution by AT.

34 Dr Adelstein, Staff Specialist in Clinical Immunology at the Royal Prince Alfred Hospital, said that as at 23 February 1995 AT was in renal failure. At about 10am on 24 February 1995 he observed signs of encephalopathy. This is a state of impairment of brain function associated with liver failure. It is usually accompanied by confusion.

35 Dr Adelstein was present at 1 pm on 24 February 1995 when evidence was taken from AT before Mr Tobin. He was surprised that AT was able to sit up and communicate during the course of that short hearing. Generally, Dr Adelstein agreed with the observation that AT was "lucid but at great effort" during the course of the proceedings.

36 There are some matters of chronology in the account set out in AT's affidavit which appear plainly wrong. Thus, AT asserts that he met BT during 1993 after he had seen the defendant for the last time. It is BT's evidence that they met in March 1992 and there is other material tending strongly to support the view that they had met not later than June 1992. AT asserted that his first consultation with the defendant took place in January 1992 whereas the defendant's clinical notes show it took place in November of the previous year.

37 AT's evidence was untested and having regard to his state of health at the time of executing the affidavit it seems to me that relatively little weight can be placed on it.

Safe Sex Advice at the 1 February Consultation

38 As noted in paragraph 31 above, AT denied that he had received any advice concerning safe sex practices in the course of his treatment with the defendant. It was the defendant's evidence that he had supplied AT with three pamphlets concerning Hepatitis B and safe sex at the consultation on 1 February 1992. The defendant attached copies of the three pamphlets to a statement, made for the purpose of these proceedings, in July 1995. That statement and the copies of the pamphlets became Exhibit V in the proceedings. In evidence the defendant sought to correct one matter. The pamphlet marked "B" forming part of Exhibit V was not a copy of the pamphlet he had given to AT. The pamphlet supplied to AT was an earlier version of the pamphlet "B". The pamphlet "B" contained reference to a journal article which had not been published as at February 1992. The defendant explained that at the time of making his statement he had attached a copy of the current version of pamphlet "B".

39 The defendant's notes of his consultation with AT on 1 February 1992 make no reference to any sexual history taking, the provision of pamphlets relating to Hepatitis B or safe sex practices, or general counselling in this regard.

40 The defendant's credit, in connection with these proceedings, was the subject of strong challenge. For reasons which I set out below I did not accept the defendant's evidence as to some matters of significance. It does not flow from this that I reject the whole of it. On this issue I consider the defendant's evidence to be preferred to the account given by AT in his affidavit.

41 AT said that the defendant had asked him whether he was gay or an intravenous drug user during his first consultation with him. On a subsequent consultation AT said he was advised he had contracted Hepatitis B. The defendant told him that it was probably contracted from a recent sexual contact.

42 The defendant's notes as to the history taken at the first consultation do not suggest any sexual history was obtained at that time beyond eliciting the information that AT was a separated man. It has not been suggested that there was any need to embark on a detailed sexual history at the initial consultation when it was not known that AT was suffering from any form of sexually transmitted disease.

43 I find that the defendant questioned AT as to whether he was gay or an intravenous drug user at the consultation on 1 February 1992 when it is common ground he told him that he had probably contracted Hepatitis B through sexual contact. I accept that the defendant had pamphlets concerning safe sex practices and Hepatitis B in his rooms at that time and that he handed AT three such pamphlets in the course of informing him of the likely cause of his infection. I do not consider the fact that the defendant selected copies of pamphlets then on issue (including one which was not available as at February 1992) when he came to make his statement to his solicitors, as being of particular significance.

The Defendant's Evidence

44 A statement signed by the defendant on 3 July 1995 was tendered in the plaintiff's case. Each of the expert witnesses was supplied with a copy of the statement and their opinions were expressed, in part, upon an acceptance of the contents of it. In the statement the defendant gave this account of the consultation with AT on 1 December 1992:

"I did not see the patient again until 1 December 1992 when he presented with fever, aches and pains, irritability and headaches. At the time, I recall that the patient seemed unwell and I was concerned that he still appeared to be troubled by the symptoms which he had previously presented with. I once again questioned him about his sexual activity and he denied any homosexual contact or multiple partners. I carried out a full physical examination of the ear, nose and throat which was normal. I also checked his right and left tympanic membrane which were normal. His lymph nodes were normal, however, there was still evidence of hepatomegaly.

I made a provisional diagnosis of a viral illness and once again considered that the patient required further investigation. I therefore ordered a full blood count, ESR and MBA20 (which includes electrolytes, urea, creatinine and liver function test). As I was concerned that the patient had had a lot of viruses, I suggested that an HIV test would be appropriate. The patient, however, did not consider that this was necessary. In view of the patient's reluctance and the fact that his history did not reveal any risk factors, I did not order the test. I asked the patient to return for review as necessary."

45 A copy of the doctor's clinical notes was also tendered in the course of the plaintiff's case. The notes for the attendance of 1 December 1992 included the following :

· denies any H/S contact or multiple partners,

· HIV not required as pt doesn't feel it is necessary,

· R/V PRN.

46 During the course of the hearing the plaintiff sought leave to uplift the original of the doctor's notes. Subsequently, Dr Walton, a document examiner, was called. In her report dated 24 June 1999 she expressed the opinion that some of the entries for the consultation on 1 December 1992 were added at a time after other of the entries. Dr Walton also noted that the page containing the notes of 1 December 1992 appeared to have been crumpled into a paper ball and subsequently flattened, probably by pressing. In the light of the defendant's evidence concerning the notes it is not necessary to dwell on Dr Walton's evidence in detail.

47 Dr Walton was the last witness called in the plaintiff's case. The defendant was not aware of the contents of her report until shortly before he was called to give evidence. It was his evidence that not all the entries recorded for the consultation on 1 December 1992 were written at the same time. He said this:

"When I started with the patient explaining about his symptoms and when I finished with the patient I realised there were a few things I have not mentioned in my records, so on the same day, later on, I added what I thought was quite important at the time."

48 The additional matters were the items which are set out in bullet points in paragraph 44 above.

49 The defendant explained that after he received the telephone call from Mr Hirsch advising him of the proposed proceedings, in a moment of anger, he had screwed up the notes. Subsequently, realising his foolishness, he had obtained his wife's assistance to iron the notes.

50 There is no suggestion that Mr Hirsch in the course of his telephone discussion with the defendant on 23 February 1995 informed him of the detail of the allegation made by his client. However, the broad outlines of the plaintiff's case were made clear to the representative of the Medical Defence Union with whom Mr Hirsch had dealings on 23 February 1995. The defendant sent a copy of the notes by facsimile to the Medical Defence Union. He was not certain when that was done but he was clear it was before he provided his detailed statement in July of 1995. The significance of this relates to the fact that the additions to the notes were of matters which were directly relevant to the present proceedings.

51 On the plaintiff's behalf it was put to the defendant that he had falsified the subject entries. He denied doing so.

52 In the course of his cross-examination the defendant stated that he had "strongly suggested" to AT that an HIV test would be appropriate during the course of the consultation on 1 December 1992.

53 The defendant was asked why he suggested the HIV test and he said this (T 238):

"Well, just looking from the history, he has had five or six attacks of fevers, chills and viral like illnesses on top of the urinary tract infection he contracted, which was not explained by the normal urinary tract abnormalities because I did a pyelogram to rule out any

abnormalities and that was normal, so one of the likelihood of contracting urinary tract infection in a male is by having anal sex."

The defendant went on to agree that anal sex is a risk factor for HIV. He was asked why, in his statement of July 1995, he had stated that AT did not reveal any risk factors. He said that this was because AT had not admitted to any.

54 In the light of the defendant's evidence it might be thought that the statement supplied by him to his solicitors in July 1995 contained two notable omissions: (i) that AT's symptoms and history suggested the possibility that he had engaged in anal intercourse (contrary to his denials) and (ii) that, accordingly, the defendant had strongly suggested AT undergo an HIV test.

55 I was not favourably impressed by the defendant's demeanour during his evidence concerning the consultation on 1 December 1992 or the circumstances in which he made the additions to his notes. I do not accept his account that he strongly advised AT to have an HIV test. Nor do I accept that the defendant suggested that AT take an HIV test and later on that day, or shortly thereafter, decided to make an addition to his notes of the consultation to record that fact.

56 In his affidavit AT denied that the defendant had at any time suggested that he undergo an HIV test. In the period 1 February to 1 December 1992 AT underwent a number of tests as requested by the defendant. He attended for follow-up consultations to learn the results of the tests. Ultimately, when Dr Koorey recommended that AT undergo an HIV antibody test, he did so.

57 I consider it more probable than not that AT was not given any advice to undergo an HIV test at the consultation on 1 December 1992.

BT's evidence

58 I have set out a number of factual findings based upon the evidence given by BT. I should note that BT's credit was the subject of challenge in the proceedings. In particular, emphasis was placed on her admission to having deliberately misled Australian consular officials in connection with her application to obtain a visa for entry to Australia (T 130). She agreed that she was attracted to emigrating to Australia because it provided better financial security for her than life in her country of birth might have done (T 129). The admission to having been willing to mislead consular officials in order to advance her financial interests must engender a degree of caution in the approach to the evidence of BT. Despite this, I was inclined to accept BT and did so in relation to the matters set out in paragraphs 16 - 27 & 29 above. On occasions her answers did not advance her interests. In particular, she acknowledged that she and AT had engaged in unprotected sexual intercourse on occasions after she was warned not to do so by her own doctor (in the light of the perceived risk of contracting Hepatitis B) (T 125/6). I believe that BT understood the significance of that evidence. The cross examiner returned to the topic the following day and BT did not endeavour to vary or qualify her account (T 136).

59 BT was challenged as to her account of being present during one of AT's consultations with the defendant. She said they had been in the defendant's rooms a relatively short time and that "he just used a syringe to clean the ear of AT" (T 160). She was questioned as to

whether AT had on that day made a number of other complaints to the defendant. While maintaining that AT's major problem on that occasion was the ringing in the ears she recalled that AT "got some more problems like stomach pain"(T 160). It was put to BT that she was mistaken in her evidence as to being present in the room when the defendant syringed AT's ears (T 161). The defendant gave no evidence to contradict BT's account of this consultation. His notes seem to me to provide support in general terms for her recollection; they record the ringing in the ears and that AT had left sided abdominal pain/constipation. It appears from the notes that the defendant did syringe AT's ears.

The Duty of Care Owed to BT

60 The plaintiff claims that the defendant owed to her a duty of care. The content of the duty said to have been owed by the defendant to BT was to diagnose AT's HIV infection and/or to give proper counselling and advice to AT as to the need for an HIV test. The duty to BT (and to any other sexual partner of AT) is discharged by the diagnosis and provision of proper advice to the patient.

61 The defendant submits that no duty was owed by him to BT. The defendant points to the following facts which are not in dispute:

· At no time was BT a patient of the defendant.

· At no time did AT disclose to the defendant the existence of a sexual relationship between himself and BT.

· At no time did AT specifically seek from the defendant any treatment for, or advice about, his HIV status.

· AT's HIV positive status was not caused by any action or inaction on the part of the defendant.

· HIV is a lifelong infection which can be transmitted to other people in a variety of ways both sexually and non-sexually. A person infected can retransmit the infection once acquired.

62 The plaintiff pleads that she "is within the class of persons who were at risk of foreseeable injury if the defendant failed to properly counsel and advise AT to have an HIV test". The defendant does not seek to contend that the plaintiff, as a sexual partner of AT, was not a person at risk of foreseeable injury but submits that something more than this consideration alone is required in order to found a duty of care; Jaensch v Coffey [1984] HCA 52; (1984) 155 CLR 549 per Gibbs CJ at 553, per Deane J at 581-583; Bryan v Maloney (1995) 182 CLR 609 per Mason CJ, Deane and Gaurdron JJ at 617-619; Esanda Finance Corporation Ltd v Peat Marwick Hungerford [1997] HCA 8; (1997) 188 CLR 241 per McHugh J at 272.

63 As the defendant submitted, the identification of the additional element required to give rise to a duty of care is not easy to discern. At the date of making submissions on behalf of the defendant it was noted that proximity is no longer a universal determinant although it was suggested it may still have some role to play. That was prior to the High Court's judgment in Perre v Apand Pty Ltd [1999] HCA 36; (1999) 73 ALJR 1190 which confirms the move away in recent years from seeing proximity as the unifying criterion of the duty of care; see

Gleeson CJ at para 9; Gaudron J at para 27, McHugh J at paras 74 and 78; Gummow J at paras 198-201; Hayne J at paras at 330-333.

64 Perre was a case arising out of a claim for negligently inflicted pure economic loss. However, there are passages in the judgements as to the ingredients of the duty of care which appear of broader application. Gummow J (with whose reasons on this aspect Gleeson CJ agreed) said:

"In determining whether the relationship is so close that the duty of care arises, attention is to be paid to the particular connections between the parties ... There is no simple formula which can mask the necessity for examination of the particular facts. That this is so is not a problem to be solved; rather, as Priestley JA put it in Avenhouse v Hornsby Shire Council (1998) 44 NSWLR 1 at 8 `it is a situation to be recognised'" (para 198).

Amongst the factors that his Honour identified as justifying a finding that a duty was owed in that case were (i) the defendant's knowledge of the risk (ii) the appellants had no way of appreciating the existence of the risk to which the respondent's conduct exposed them and, thus, had no avenue to protect themselves (at para 216).

65 McHugh J placed emphasis on the vulnerability of the plaintiff to incurring loss in consequence of the defendant's conduct. His Honour considered that the defendant's knowledge of the risk and its magnitude would be relevant in all pure economic loss cases and might be relevant in other circumstances (paras 104, 105 and 129).

66 In Hill v Van Erp (1997) 188 CLR 159 the majority found the solicitor owed a duty of care to the third party/beneficiary. That was a case involving a claim for pure economic loss, although the facts did not give rise to concerns as to indeterminacy either in the number or extent of claims. The suggestion that the imposition of a duty in favour of the third party conflicted with the solicitor's duty to her client was rejected; the interests of the solicitor's client and the plaintiff being coincident.

67 Of the recent decisions of the High Court dealing with constituent elements of the duty of care in the law of negligence to which I was taken, Pyrenees Shire Council v Day [1998] HCA 3; (1998) 192 CLR 330 is the only one not concerned with a pure economic loss claim. However, its usefulness for present purposes is limited to some degree by the centrality of the statutory powers of the Council to the way in which their Honours decided the case.

68 In the course of his reasons in Pyrenees, Gummow J observed that the situation occupied by the Shire "gave it a significant and special measure of control over the safety from fire of persons and property". His Honour went on:

"[the] statutory enablement of the Shire `facilitate[d] the existence of a common law duty of care' but the touchstone of what I would hold to be its duty was the Shire's measure of control of the situation including its knowledge, not shared by Mr and Mrs Stamatopoulos or by the Days, that, if the situation were not remedied, the possibility of fire was great and damage to the whole row of shops might ensue. The Shire had a duty of care `to safeguard others from a grave danger of serious harm', in circumstances where it was `responsible for its continued existence and [was] aware of the likelihood of others coming into proximity of the danger and [had] the means of preventing it or of averting the danger or of bringing it to their knowledge'." (at para 168).

69 In Pyrenees, in determining that a duty of care was owed, Kirby J referred especially to the risk of danger, the latency of the defect and the inability of the claimants to protect themselves (at para 255).

70 The defendant submitted in a case such as the present in which a duty of care is said to arise in novel circumstances, while a process of reasoning by analogy from decided cases may be appropriate, I would bear in mind the injunction that there is no scope for decision by reference to idiosyncratic notions of justice and morality: Sutherland Shire Council v Heyman [1985] HCA 41; (1985) 157 CLR 424 per Deane J at 498. This is not to say that considerations of public policy do not underlie the determination of the existence of a duty of care in novel cases as Deane J explained in the above passage. Unsurprisingly both the plaintiff and the defendant have addressed submissions as to what are said to be the competing reasons of policy for and against the existence of a duty.

71 In the present case the plaintiff submits that the defendant by virtue of his specialist training and knowledge, was in a position to know (or should have known) that in the light of AT's history and symptoms AT was at risk of having contracted HIV. It was reasonably foreseeable that AT, if HIV positive, would transmit the virus to sexual partners. Neither AT nor his sexual partners may be in a position to understand the risk (AT had not progressed to an AIDS related illness at the material time). In this respect AT's HIV condition was latent. In determining whether a duty is owed it is submitted that the magnitude of the risk is an appropriate matter to take into account.

72 The plaintiff relied on three North American decisions in which like issues have arisen. In Pittman Estate v Bain (1994) 112 DLR (4th) 257, Lang J in the Ontario Court (General Division) dealt with such a case at first instance. A patient undergoing cardiac surgery at the Toronto Hospital in 1984 received a transfusion of blood from a donor who was HIV positive. In 1989 the head of the hospital's blood bank informed the patient's doctor that the transfusion had been contaminated. The doctor was concerned about the effects of this news on his patient's mental and cardiac condition. He took the view, wrongly, that the patient was no longer engaging in sexual intercourse. Having regard to these considerations he determined not to inform his patient of his possible HIV status. The patient died in March 1990 and at that time it was discovered that he was HIV positive. In September 1990 the patient's wife was diagnosed as being HIV positive. She, and the estate of the deceased husband, commenced proceedings against the doctor.

73 Lang J found that the doctor had a duty to inform his patient of the possibility that he had contracted HIV. He found that the doctor had breached that duty. His Honour went on to observe (at 401) that:

"[i]n this context, it is unnecessary for me to determine whether Dr Bain had an independent duty to Mrs Pittman, because Dr Bain did have an obligation to tell Mr Pittman, and if he had told Mr Pittman, the evidence established that Mr Pittman would have told his wife."

74 His Honour proceeded to an assessment of damages for the injuries sustained by the plaintiff wife. No alternative basis for compensating her, save that the defendant doctor breached an independent duty owed to her, was advanced. However, as appears from the passage extracted above the decision did not involve an analysis of the basis upon which his Honour arrived at the determination and is thus of little guidance for present purposes.

75 The plaintiff also relied on the decision of Reisner v Regents of the University of California 37 Cal Rptr 2d 518 (1995). In that case a twelve year old girl received a transfusion of blood contaminated with HIV. The following day her doctor discovered that the blood was contaminated. He determined not to tell the child or her parents of that fact. Three years later the girl commenced a relationship with the plaintiff. They engaged in sexual intercourse. Two years later the defendant doctor informed the girl of her HIV status. She in turn informed the plaintiff who was tested and found to have contracted HIV. The plaintiff commenced proceedings against the defendant doctor.

76 The defendant doctor in Reisner moved successfully for summary judgment. The plaintiff appealed. The California Court of Appeal noted that the defendant had conceded that:

"[w]hen the avoidance of foreseeable harm to a third person requires a defendant to control the conduct of a person with whom the defendant has a special relationship (such as physician and patient) or to warn the person of the risks involved in certain conduct, the defendant's duty extends to a third person with whom the defendant does not have a special relationship." (at 520)

In Reisner it was the plaintiff's case, as here, that the defendant's duty was discharged by warning his patient (or her parents). The court appears to have accepted the view that the plaintiff was a reasonably foreseeable plaintiff, even though his actual identity was neither known to nor ascertainable by the defendant. It noted (at 521):

"[He] knew or reasonably should have known that, as she matured, Jennifer was likely to enter an intimate relationship."

77 The court found that the defendant doctor owed a duty to the plaintiff, as a reasonably foreseeable person, to warn his patient of the likelihood that she was infected and of the need, accordingly, for her to take appropriate precautions. It concluded that:

"[o]nce the physician warns the patient of the risk to others and advises the patient how to prevent the spread of the disease, the physician has fulfilled his duty - and no more (but no less) is required." (at 523)

It is to be noted that in Reisner the defendant doctor's knowledge was of the fact of the transfusion of blood contaminated by HIV antibodies.

78 The plaintiff also relied on Di Marco v Lynch Homes-Chester County Inc 583 A 2d 422 (1990). In that case a health worker suffered a needle stick injury while taking blood from an elderly resident at the defendant's nursing home. She was advised that the resident was a carrier of Hepatitis. She sought medical advice and was informed that if she did not contract Hepatitis within six weeks she would not contract it at all. She was further advised not to engage in sexual intercourse during the six week period. She refrained from sexual relations for an eight week period but thereafter resumed a sexual relationship with the plaintiff, with whom she did not live. She and the plaintiff were subsequently diagnosed as suffering from Hepatitis B.

79 The plaintiff brought proceedings before the Court of Common Pleas of Philadelphia County. The proceedings were dismissed, the court noting that physicians do not have control

over the sexual conduct of their patients. The Superior Court of Pennsylvania reversed the finding of the Court of Common Pleas and remanded the matter; Di Marco v Lynch Homes-Chester County Inc 559 A 2d 530 (1989).

80 The decision of the Superior Court was appealed to the Supreme Court of Pennsylvania. The decision of the Superior Court was affirmed by majority (Larsen, McDermott, Papadakos and Cappy JJ; Nix CJ, Flaherty and Zapalla JJ dissenting): Di Marco v Lynch Homes-Chester County Inc 583 A 2d 422 (1990). The majority observed that when a physician treats a patient who has been exposed to a communicable disease it is imperative that the physician give the patient proper advice in order to prevent the spread of the disease. Such measures are necessary not for the benefit of the already infected patient, but with a view to the protection of others. They observed:

"the duty of a physician in such circumstances extends to those `within the foreseeable orbit of risk of harm' ... If a third person is in that class of persons whose health is likely to be threatened by the patient, and if erroneous advice is given to that patient to the ultimate detriment of the third person, the third person has a cause of action against the physician, because the physician should recognise that the services rendered to the patient are necessary for the protection of the third person" (at 424-425).

81 Their Honours concluded (at 425) that:

"the class of persons whose health is likely to be threatened by the patient includes anyone who is physically intimate with the patient. Those, like the trial court, who insist that we cannot predict, or foresee, that a patient will engage in sexual activity outside of the marital relationship and that thus, we need not protect those who engage in `casual' sex, are exalting an unheeded morality over reality."

82 The question of whether a duty is owed by a health service provider to the sexual partner of a patient was considered by the Court of Appeal in Goodwill v British Pregnancy Advisory Service [1996] 2 All ER 161. In that case the plaintiff's boyfriend, Mr McKinlay, had undergone a vasectomy before the couple met. When they commenced their sexual relationship he told her of the procedure and of his advice that it had been successful. Subsequently the plaintiff conceived a child and became aware of the pregnancy when it was too late for an abortion. She brought proceedings seeking damages for the expenses associated with her daughter's birth and the costs of raising her. The court found that the defendants were not in a special relationship with the plaintiff such as to give rise to a duty of care. Emphasis was placed on the circumstance that the plaintiff was not Mr McKinlay's sexual partner at the time the defendants advised him. The class to which the plaintiff belonged was any woman who might be a potential sexual partner of Mr McKinlay over the span of his life. This was too uncertain a class to impose any duty of care upon persons advising Mr McKinlay as to his fertility.

83 It is to be noted that Goodwill was a claim for pure economic loss based upon a third party's reliance on negligent advice.

84 The defendant submitted that before a duty can be held to arise it is essential that the plaintiff is known to or capable of being readily identified by the tortfeasor.

85 With respect to consequential economic loss the defendant acknowledged that it may sometimes be sufficient if the class is "capable of being ascertained": Caltex Oil (Australia) P/L v The Dredge `Willemstad' [1976] HCA 65; (1976) 136 CLR 529 at 555. In such cases, the defendant submitted, there must nevertheless be a degree of certainty about the identity of the individual. In this sense merely being able to describe a class is not enough. Relying on Alcock v Chief Constable [1991] UKHL 5; [1992] 1 AC 310 at 410E the defendant submitted that the impracticability or unreasonableness of entertaining claims to the ultimate limits of human activity tells against the existence of a duty.

86 The defendant submitted that the class to which BT belongs must as a matter of logic include not only all sexual partners including future sexual partners but also others at risk of infection by AT. Thus health workers or others who might come into contact with AT's blood products would also fall within it. The members of the class may not be in existence at the time of the tortious conduct. They bear no relation to the defendant and are not capable of being known to him or ascertained by him.

87 I do not consider that the fact that the members of the class may not be known or be capable of ready identification by the defendant is determinative of there being no duty of care. In Voli v Inglewood Shire Council [1963] HCA 15; (1963) 110 CLR 74, in finding that the architect owed a duty, Windeyer J observed that the architect:

"knew the purpose for which the hall was being built, and the use to which it would be put. His duty of care extended to persons who would come there to use it in the ordinary way" (at 85).

There was no pre-existing relationship between the architect and the plaintiff in that case. The architect at all relevant times was unaware of the plaintiff's existence. The plaintiff could only recover upon the basis that he was a member of a reasonably foreseeable class of persons. The defendant acknowledged as much in his written submissions observing:

"On some occasions, a known class of people may suffice for a duty to be owed but this is capable of ready identification and has a physical relationship/proximity with the tortfeasor. See Voli v Inglewood Shire Council [1963] HCA 15; (1963) 110 CLR 74". (Defendant's outline of submissions para 13.2).

88 The class to whom the architect owed a duty were all those persons who came into the hall lawfully to use it in the ordinary way. Viewed in that way the architect's duty was potentially to a very large and unidentified group.

89 It does not seem to me that the policy considerations concerning indeterminate liability are raised by the facts of this case more acutely than in Voli.

90 The defendant submitted Voli involved the same sort of direct infliction of physical injury as is seen in the motor vehicle collision cases. The stage collapsed because it was constructed in accordance with the defendant's negligently prepared plans. It was in this context that the finding of the duty should be understood. In contrast it was contended that the cause of BT's injury was the sexual contact between her and AT. The duty alleged by the plaintiff here, so it was submitted, is in effect identical with a duty to rescue; to save BT from a harm which was not caused by the defendant. It is the plaintiff's case that she suffered injury in consequence of the defendant's negligent failure to diagnose and or adequately advise her sexual partner as

to his risk of infection with a fatal sexually transmissible viral illness. On her behalf evidence has been led to establish that the great majority of persons, if made aware of their HIV positive status, will avoid exposing their partners to risk of infection. The rescue analogy requires a restrictive view of the cause of the plaintiff's injury. It does not in my view hold good.

91 I note the issue of a medical practitioner's duty with respect to rescue was dealt with in Lownes v Woods (1996) Aust Torts Reports 81,376. That case has significance for the way in which the Court took into account the obligations imposed on medical practitioners under the Medical Practitioners Act 1938 on the question of whether it was appropriate to impose a duty of care on the doctor in relation to a person (in need of urgent treatment) who was not his patient. The majority held that the primary judge had been right to take into account the statutory obligation (to provide attention) in determining that a relationship of proximity had been made out.

92 It is to be noted that s 12(1) Public Health Act 1991 requires a medical practitioner who believes on reasonable grounds that his or her patient is suffering from a sexually transmissible medical condition to provide the patient with such information as is required by the Regulations made under that Act. Regulation 4 of the Public Health Regulation 1991 sets out the categories of information which is to be supplied:

(a) means of minimising the risk of infecting other people with the condition;

(b) public health implications of the condition;

(c) responsibilities under s 11 of the Act, including any precautions considered reasonable;

(d) responsibilities under s 13 of the Act;

(e) diagnosis and prognosis;

(f) treatment options.

93 Section 13 of the Public Health Act makes it an offence for a person who knows that he or she suffers from a sexually transmissible medical condition to have sexual intercourse with another person unless, before the intercourse takes place, the other person has been informed of the risk of contracting a sexually transmissible medical condition and has voluntarily agreed to accept that risk.

94 The scheme of the Public Health Act thus requires a medical practitioner who reasonably believes his or her patient to have HIV to inform the patient of the public health implications of the condition and of the means of protecting others. The practitioner must inform the patient of the patient's statutory responsibility to warn prospective sexual partners of his or her condition. These provisions seem to me to have some bearing on the submissions with which I next deal concerning conflict of interest, therapeutic privilege and doctor/patient confidentiality as well as the broader question of whether it is appropriate to impose a duty such as that pleaded on a practitioner in relation to the sexual partners of his or her patients.

95 The defendant submitted that there are policy reasons which tell against a duty being owed by the defendant to BT. Firstly, any such duty, it was submitted, may involve a conflict with

the duty owed by the defendant to AT. A doctor's duty to his patient does not permit him to place the interests of any person above those of his patient. A conflict, actual or potential, is a strong policy reason, so it was submitted, to hold against the existence of a secondary duty to a person such as BT. Such a submission would have more force if it were being suggested that the content of the duty required the doctor to warn his patient's sexual partners. That is not the case here. The duty is discharged by the doctor providing his patient with appropriate and adequate advice. In such a circumstance it is difficult to see how as a matter of practical reality a conflict could arise.

96 The defendant submitted that a potential for conflict arose in the context of the therapeutic privilege which may justify a doctor in withholding information from his or her patient where it is in the patient's best interests so to do. In a case where a medical practitioner believes on reasonable grounds that his or her patient has contracted HIV, therapeutic privilege would not, in the light of the statutory obligation cast on the practitioner, allow of a decision to withhold information either as to the patient's status or obligations with respect to notifying sexual partners.

97 The defendant also relied upon the confidentiality of the doctor/patient relationship. In written submissions it was put this way:

"The only person who can release the doctor from the obligation of confidence is the patient. But if a duty is owed to a third party by the doctor, then in order to discharge that duty it may be necessary for the doctor to breach the obligation of confidentiality. Which is to prevail? That is an impossible choice. The only course open is to hold that there is no duty."

In the way the plaintiff pleads her case considerations of confidentiality do not strike me as raising issues of real substance. There is no suggestion that the obligation on the doctor extends beyond the provision of adequate advice to the patient.

98 I consider in the circumstances of this case that the plaintiff has established that the defendant owed to her a duty of care. In arriving at this conclusion I have taken into account the following matters:

· There is no conflict between the duty owed by the defendant to AT and BT as the two are coincident;

· BT was a sexual partner of AT;

· It was reasonably foreseeable that AT, if HIV positive, would transmit the virus to a sexual partner;

· AT's was unaware of his HIV status (in this respect the condition was latent);

· The defendant's specialist knowledge and training equipped him to identify the risk that AT had contracted HIV;

· Failure to diagnose and adequately counsel AT to undertake an HIV antibody test exposed AT's sexual partner/s to the real risk of contracting a fatal disease.

It is the combination of these factors, together with a consideration of public policy reflected in the statutory obligations placed upon medical practitioners with respect to the treatment of and supply of information to patients with sexually transmissible medical conditions, which to my mind makes the imposition of the duty appropriate in the circumstances of this case.

Breach of Duty

99 The nature and content of the defendant's duty to AT (and by extension to BT) is as set out in Rogers v Whitaker [1992] HCA 58; (1992) 175 CLR 479 489-490 and 492-493. It is to exercise the reasonable care and skill expected of a general practitioner in 1992. It is alleged that the defendant fell below that standard in his failure both to consider a possible diagnosis of HIV and to advise appropriately. In this case expert evidence as to the practice of general practitioners in 1992 plays an influential role in ascertaining the standard demanded by the law.

100 The plaintiff submits that reasonably informed general practitioners practising in the inner city suburbs of Sydney in 1992 would have been aware of the association between Hepatitis B (and other sexually transmissible diseases) and HIV.

101 It is the plaintiff's case that as at 1 February 1992, when AT's Hepatitis B was confirmed and the defendant obtained a history which included reference to AT's "casual exploits" as a possible source of his infection, the defendant's failure to consider a diagnosis of HIV and to counsel AT to undergo an HIV antibody test fell below the standard of skill and care of an ordinary general practitioner practising in Sydney in 1992.

102 By the 1 December 1992 consultation when AT returned reporting fever and aches and pains it is submitted that the defendant was even more clearly on notice of HIV as a possible diagnosis such that, even if he suggested an HIV test (which is not accepted), his advice was inadequate and, again, fell below the standard of a general practitioner exercising ordinary care and skill.

103 The plaintiff relied on the evidence of Drs Law, Furner and Fisher. Dr Fisher is a very experienced general practitioner. His many appointments include a term as President of the Royal Australian College of General Practitioners. In a report dated 4 July 1996 Dr Fisher expressed the following opinion:

"A reasonably informed general practitioner practising in inner city Sydney in 1992 to 1993 would in my opinion have recognised that where a man is an active heterosexual, who practises unprotected sexual intercourse and has Hepatitis B believed to have been acquired sexually would assume that the man may well have been exposed to HIV. He ought therefore have been counselled and advised to have an HIV test and to only have protected sexual intercourse whilst he is infectious with Hepatitis B."

Dr Fisher went on to note that in his opinion a reasonably informed general practitioner practising in the inner city of Sydney in 1992 to 1993 would have recognised that fevers, night sweats, lethargy, lymphadenopathy and chronic ill health during early 1992 were consistent with lowered resistance and HIV infection. He noted that the period of generally good health experienced by AT between March and December 1992 followed by a recurrence of symptoms was also consistent with HIV infection. It should be noted that there is no evidence that AT gave a history of night sweats to the defendant.

104 Dr Fisher's evidence was that in 1992 a reasonably competent general practitioner would have been aware of the link between Hepatitis B and HIV (T141). He considered the presence of Hepatitis B mandated advice as to HIV testing. He rejected the proposition that such a view represented an extreme position with respect to the standard expected of a reasonably competent general practitioner in 1992 (T 148).

105 Dr Carmela Law was qualified as a sexual health physician who has been involved with GP education for more than ten years. She is a fellow of the Australasian College of Sexual Health Physicians. She is the Director of the Manly Sexual Health Service. In particular she has created and taught a course on `sexual history taking skills'. The need for such a course appears to have been identified by her when she was co-ordinator of medical student teaching on sexual health for the Universities of Sydney and New South Wales in 1991. Additionally, she has conducted a training programme for general practitioners on sexually transmitted diseases.

106 The defendant submitted that I should be careful in accepting the opinion of Dr Law as to the standard of care expected of general practitioners in 1992 because her practice is a specialised one. The patients who present to the Manly Sexual Health Service are not representative of the spectrum of patients attending an ordinary general practice in inner-city Sydney. That is so. However, Dr Law made allowance for that. In her report when she addressed the question of the level of publicity in 1992 about seroconversion illness and the similarity of risk factors for transmission of HIV and Hepatitis B, she was looking, as I understand it, not at the information available to specialised sexual health practitioners but to that available to those in general practice.

107 Dr Law was inclined to posit a less rigorous standard for general practitioners than was Dr Fisher. Dr Fisher was of the view that the presence of Hepatitis B (presumed to be sexually acquired) in a heterosexual male mandated the need for an HIV antibody test. On this view the defendant's failure to recommend one on 1 February 1992 was negligent. In her report Dr Law took into account the demands of general practice and considered it understandable that a diagnosis of HIV infection might be missed on the first occasion. The combination of Hepatitis B infection and the admission of "casual exploits" together called for a detailed sexual history taking. She went on to comment that there were several consultations following that on 1 February 1992 which offered opportunities to reconsider the diagnosis, retake the history, confer with colleagues and generally review the case as there were ongoing symptoms (report para 4 p 3). By the 1 December 1992 consultation Dr Law was of the opinion that there was a need for a detailed sexual history taking (report para 1 p 1). In evidence Dr Law explained it was important to conduct a risk assessment because Hepatitis B is a sexually transmissible disease (T 48).

108 Dr Furner, the Deputy Director of the Albion Street Centre, a specialist service providing comprehensive treatment for patients with HIV/AIDS, stated in her report dated 30 May 1997:

"I completely agree with the proposition that where a heterosexual is diagnosed as having Hepatitis B that was presumably sexually acquired the patient ought to be counselled regarding the advisability of a HIV test. There is strong epidemiological evidence that patients can acquire more than one sexually transmitted disease simultaneously, and that the presence of sexually acquired Hepatitis B infection must always alert a clinician to the

possibility of co-infection with HIV, and additional tests should be conducted to exclude this possibility."

109 Dr Furner was an impressive witness and I had no hesitation in accepting her evidence. However, it is to be noted that the opinion set out above is not directed to the situation as it stood in 1992 with respect to the standard of competence of general practitioners. This is an important consideration. I did not understand any of the expert witnesses (with the possible exception of Dr Gray whose report did not address this issue) to gainsay the proposition that as at 1997 (the date of Dr Furner's report) a prudent general practitioner would recommend an HIV antibody test in the presence of Hepatitis B believed to have been sexually acquired. There was evidence that the Commonwealth Government had sponsored a programme of education for general practitioners to so advise them in 1993/1994.

110 Associate Professor Graeme Stewart, Director of the Department of Clinical Immunology at Westmead Hospital, gave evidence in the defendant's case. Professor Stewart has a lengthy and distinguished career involvement relating to HIV disease, both clinically and in the development of government policy.

111 Professor Stewart was asked to comment in his report on the state of knowledge of the general public regarding HIV infection and its transmission and Hepatitis B infection and its transmission as well as the nature of the information available to the public in this regard in the period 1992 - 1993. He said that it was difficult to be certain of the state of knowledge of the general public in 1992 - 1993. Following the "Grim Reaper" campaign in the 1980's he considered that "it would be most unusual for a sexually active adult not to be aware that HIV infection is transmitted sexually both by homosexual and heterosexual contact" (report para 10). Professor Stewart went on to state that the level of public knowledge with respect to the transmission of Hepatitis B would have been less although he did not profess to be expert to comment in the area of Hepatitis B.

112 In 1992 Professor Stewart was concerned that the diagnosis of HIV was one commonly missed. He explained that since many doctors had graduated before HIV was identified, this was not surprising. It was Professor Stewart who persuaded the Commonwealth Government in that year to fund the national education programme to which I have referred. This was conducted during 1993 and 1994 under the title "Could it be HIV?". A series of articles published in the Medical Journal of Australia in the period January to March 1993 on the topic of HIV were bound into a monograph and distributed to every doctor and medical student in Australia. The defendant would have received his copy after his last consultation with AT.

113 In summary, Professor Stewart expressed his opinion thus:

"I do not believe that a reasonably competent general practitioner during the period of 1992 to January 1993 would have been expected to diagnose HIV infection in this circumstance, particularly taking into account AT was a heterosexual man in Australia. Diagnosing HIV infection in clinical practice can be extremely difficult and exceptionally so for patients who are not in an identified high risk group."

114 Professor Stewart considered that if AT was homosexual or bisexual it would have been inappropriate not to have arranged an HIV test but in his view it was commonplace not to do so in relation to a heterosexual man (T 191-192). Similarly, if a patient stated he had had sex

with a sex worker, that would raise a suspicion in relation to the desirability of an HIV test (T 195).

115 The defendant also relied on the report of Dr Gray, general practitioner. In Dr Gray's view an HIV test would not necessarily be recommended as part of the investigation of a patient with Hepatitis B. In his opinion there was nothing in the investigations carried out on AT or his clinical presentation which would necessarily suggest a diagnosis of HIV or warrant HIV testing. In this regard the doctor said in his report:

"AT did not have all of the predisposing factors and in retrospect the fact that he was HIV positive did not appear until much later, after passing through the hands of quite eminent specialists."

Dr Gray considered that the supply of pamphlets to AT was sufficient advice relating to his Hepatitis B condition and safe sex practices generally.

116 It is to be noted that both Dr Gray and Professor Stewart remarked on the fact that other doctors dealing with AT after the defendant had ceased treating him did not appear to consider a diagnosis of HIV until November 1994 when Dr Koorey did so. If it be the case that a reasonably competent general practitioner in Sydney in 1992 should have considered a diagnosis of HIV having regard to the history taken and the symptoms observed by the defendant, the fact that other practitioners might have failed to meet that standard would not assist the defendant.

117 Dr Gray's answer to the question of whether an HIV test would normally be recommended as part of an investigation of a patient with Hepatitis B was in these terms: "Not necessarily ... as the symptoms of AT were very like Hep B but also could have been those of AIDS which was diagnosed much later but probably not present at this stage". I do not understand any of the plaintiff's experts to be suggesting that AT's symptoms were consistent with AIDS, but rather that the presence of a sexually transmitted disease should have alerted a competent practitioner to the possibility that the patient may also have contracted HIV. Dr Gray's report does not in terms address this issue. He was not available for cross examination and accordingly the matter was not taken further. I take Dr Gray to be asserting that as at 1992 in his view a competent practitioner would not necessarily (in the sense of without more) have advised an HIV test in a case where a patient presented with Hepatitis B.

118 The defendant's evidence is that as at the consultation on 1 December 1992 he had regard to AT's history of viral illnesses and the combination of Hepatitis B with a urinary tract infection and that he considered the possibility of HIV infection. The results of the pyelogram excluded other causes for the urinary tract infection leaving the defendant with the suspicion that AT may have engaged in anal intercourse. The defendant was aware of anal intercourse as a risk factor for HIV. In evidence the defendant said that he advised AT to have an HIV antibody test and that that advice was in strong terms. If that were the case the defendant would have discharged his duty to AT (and BT). For the reasons already given above I do not accept that the defendant advised AT in strong terms to have an HIV test.

119 If the defendant, mindful of the matters set out in paragraph 118 above, suggested to AT that he consider an HIV test and took the matter no further when AT said that he did not think

it was necessary, would his conduct fall below the standard of ordinary care and skill of a general practitioner at that time?

120 Dr Law stated that patients often cannot accurately assess their level of risk (report para 4 p.3). This seemed to me to be an unexceptional observation and I do not understand any of the expert witnesses to be in disagreement with it. Dr Furner drew a distinction between suggesting that a patient undergo an HIV test and recommending that they do so. In her report of 30 May 1997 Dr Furner said "when a patient expresses the sentiment that HIV test is not required, `as they do not feel it is necessary' they should be adequately counselled as to the advantages of having the test performed" (para 3 pp.1/2). Dr Fisher said it was necessary to explore with a patient the reasons for the patient's refusal (T155). It should be observed that the defendant does not assert that AT refused to undergo a test but rather that he said he did not think one was necessary.

121 It seems to me that if on 1 December 1992 the defendant did turn his mind to the real possibility that, contrary to his assertions, AT had engaged in homosexual relations involving anal intercourse and he knew him to have contracted Hepatitis B and to have a history of recurrent viral illness, it was incumbent on him in the exercise of ordinary skill and care to recommend that he undergo an HIV antibody test. It was necessary to take time to impress the need for this on AT and not to accept an initial expression of disinclination.

122 I do not take Professor Stewart to be of a contrary view. In the event that a practitioner had a suspicion that his patient was homosexual or bisexual it would be appropriate to recommend an HIV test in the presence of Hepatitis B (T191/2). Dr Gray's report did not deal with this issue since he was commenting on the defendant's statement which referred to his acceptance of the patient's reluctance to undertake an HIV test for the reason that he had no risk factors. Dr Gray did not comment upon what might have been the appropriate course had the defendant suspected that AT's sexual history included acts of anal intercourse.

123 As I have indicated I do not accept the defendant's evidence as to the consultation on 1 December 1992. It flows from this that I do not accept the evidence that he was at the time of a mind to suspect that AT had engaged in homosexual relations. I think it more probable than not that the defendant did not give consideration to this (or HIV infection) as a possibility at the time.

124 Accordingly, I turn now to a consideration of whether in 1992 a general practitioner of ordinary skill and care should have considered a diagnosis of HIV (and advised of the need for a test) in the case of a heterosexual male who presented with Hepatitis B presumed to have been sexually acquired and who had a history of recurrent viral illnesses and a urinary tract infection.

125 Dr Fisher would say yes to the above question. By the consultation on 1 December I understand Dr Law to also be of that view. Unlike Dr Fisher, I took Dr Law to be saying not that one would automatically test for HIV in the presence of Hepatitis B but rather that the presence of the latter put the practitioner on notice of the need for further inquiry. A full sexual history risk assessment might in turn lead to the need for HIV testing. In this case disclosure of the sexual contact with a prostitute would have done so. Professor Stewart agreed sexual contact with a prostitute was a risk factor for HIV. In any event by the December 1992 consultation when AT presented with signs of further viral illness it was

necessary to consider a diagnosis of HIV and to recommend that a test be undertaken. This it seemed to me flowed from the evidence of Drs Fisher and Law.

126 In evidence Professor Stewart was not prepared to say that the defendant should have concluded that AT's Hepatitis B was likely sexually acquired. He acknowledged that the science would suggest that to be the case but he was careful to distinguish between "what the world knows and what the individual practitioner knows" (T 185). In this case, of course, it is accepted that the defendant was of the view that AT's Hepatitis B was sexually acquired. Thus it was not entirely clear that Professor Stewart in expressing the opinion that in 1992 a reasonably competent general practitioner would not have been expected to diagnose HIV infection in this circumstance was taking into account that AT was suffering from one sexually transmitted disease. However, I note that Professor Stewart was supplied with a copy of the defendant's statement and I understand the opinion expressed in the final paragraph of his report to be based upon a review of the whole of the material supplied to him. I take him to be of the view that looking back to the state of knowledge in 1992 a reasonably competent practitioner would not have been expected to diagnose HIV infection in the presence of Hepatitis B presumed to be sexually acquired.

127 Professor Stewart was not at odds with Drs Fisher, Furner or Law in considering the need to investigate for HIV in the presence of a sexually transmitted disease. The point of departure related to the presumed knowledge of an ordinarily competent general practitioner in 1992.

128 I understood Professor Stewart to be saying that a person who presents with a sexually acquired disease ought to be counselled to undergo an HIV test but that in 1992 it was common for doctors in general practice not to make this link in the absence of a risk factor such as homosexuality or intravenous drug use. He put it this way in the course of cross examination:

Q. It follows necessarily that he has been infected by somebody who had the disease. Wouldn't you as a matter of simple commonsense then want to ask yourself the question well if the person has got that sexually transmitted disease we had better make sure that he hasn't got some other sexually transmitted disease because he got it from a diseased person. Isn't that a perfectly reasonable sensible thing to do?

A. Yes, most of the other sexually transmitted diseases would have manifested themselves with some clinical expression of it, and the history taking would have actually looked at those. So what you are really asking me is shouldn't you have also thought about HIV in that circumstance.

Q. Yes?

A. And again we have to cast our minds back to what was in the minds of people in the early 90s. Can I remind you that well into, late into the 80s there were still people who were publicly saying that heterosexual spread of this virus did not occur except in the presence of other genital lesions. You might remember the grim reaper campaign which was around 1990 in which there was great criticism of the image being treated that everybody in the community was at risk (T 190-191).

129 It was Dr Fisher's view that initially (when HIV was first recognised) the homosexual community was identified as the source of transmission of it and that later it came to be recognised that any sexual activity, whether homosexual or heterosexual, could promote the spread of it. As at 1992 the latter recognition should have been in the minds of competent general practitioners (T 157). I accept that evidence. It was in accord with the views of Dr Law. Professor Stewart's observations as to the impact of the "Grim Reaper" campaign in drawing to attention the potential for HIV to be spread by heterosexual contact seem to me to be consistent with this aspect of Dr Fisher's opinion.

130 It was submitted that I would treat the evidence of Dr Fisher with caution since it was urged he had adopted the role of advocate for the plaintiff's case. In this respect he was criticised for producing a supplementary report attaching a copy of a journal article which appeared in the November 1991 issue of the Medical Journal of Australia. In cross examination it emerged that the supplementary report was prepared at the prompting of the plaintiff's solicitor who had located the subject article, copied it and sent it to Dr Fisher with the request that he submit a report annexing it.

131 Central to Dr Fisher's opinion, as I understood it, was that the presence of a disease believed to have been sexually transmitted should as at 1992 have alerted a reasonably competent general practitioner to the possibility of HIV infection. Hepatitis B was known to be transmitted by sexual contact. The article attached to the doctor's later report was titled: "The failure of many to associate HIV infection with other sexually transmitted diseases". It was written by Professor Dwyer. It referred to the results of research carried out by Dr Gavin Hart published in the same issue of the journal. Dr Fisher had not read the underlying article. In cross examination he agreed that Dr Hart's paper referred to named sexually transmitted diseases and that Hepatitis B was not one. Thereafter the following exchange occurred:

Q. It can't be, can it, that Professor Dwyer's editorial provides any support for a proposition that it was mandatory to test for HIV in the presence of hepatitis B in the period December 1991 through to January 1993, that's so, isn't it?

A. I don't agree with that proposition.

Q. Point to me the words in Professor Dwyer's editorial that support that proposition?

A. There are no words in Professor Dwyer's proposition, but what he does say is that people who have sexually transmitted diseases should have HIV testing. To point out a few words of the specific areas which were looked at in the original article is really ignoring the fact that sexually transmitted diseases are sexually transmitted and it is - and the only way in which you can get hepatitis B is in the same way as you can get HIV, that is by intravenous drug use or by sexual transmission (T 147).

132 As I have already noted, it is clear that the defendant proceeded upon the basis that AT's Hepatitis B infection was sexually acquired and that the likely cause was a `casual exploit'.

133 I accept Dr Fisher's evidence that the presence of Hepatitis B (believed to have been sexually acquired) should have alerted a reasonably competent practitioner in 1992 to the possibility that his/her patient had contracted other sexually transmitted diseases including HIV. However, it does not flow from that that the plaintiff has established that as at the consultation on 1 February 1992 the defendant was negligent in failing to recommend an HIV

antibody test. I am mindful of Dr Law's recognition that the demands of general practice are such that on the first occasion a practitioner may not (in 1992) have succeeded in obtaining a detailed sexual history from the patient. Professor Stewart gave evidence that the referral of a patient for an HIV test might itself be traumatic from the patient's perspective. I accept that this consideration may have inclined a competent practitioner to see the need to take a full history before making a decision about referring the patient for an HIV antibody test.

134 I am satisified that as at 1 December 1992 when AT returned to the defendant's rooms apparently suffering a further viral illness, having regard to the likelihood that the Hepatitis B was contracted as the result of sexual contact and in the light of the earlier history of viral illnesses, a general practitioner exercising ordinary care and skill would have considered a diagnosis of HIV and counselled the need for an HIV antibody test.

135 I consider that as at 1 December 1992 the defendant was negligent in failing to diagnose the possibility of HIV infection and to counsel AT as to the need to undergo an HIV antibody test.

Causation

136 Did the defendant's negligent failure to diagnose AT's HIV infection and/or to give adequate counselling and advice to AT as to the need for an HIV test cause or materially contribute to the contraction of that virus by the plaintiff? A number of factual issues need to be determined in order to answer this question.

Had AT undergone an HIV antibody test in the period 1 February 1992 to 30 January 1993 would the test result have shown him to be positive?

137 When the diagnosis of HIV was made in November 1994 AT's CD4 cell count was 180/ml. It is not possible to deduce from the CD4 cell count the time at which an individual contracted the virus. The rate of decline in CD4 cells varies from one individual to another. One can only in any precise way determine the time of infection by evidence of the change from a negative HIV antibody test to a positive test. Negative tests were not available either with respect to AT or BT. Professor Stewart stated that a reduction in CD4 positive T cells from a normal level of around 1000/ml to a dangerously low level of below 100/ml occurs over a period of about ten years if the patient is untreated. It is at that point that a high likelihood of the development of life-threatening, opportunistic infections is present.

138 Dr Adelstein gave evidence that it is difficult to reach a CD4 cell count of 200/ml in less than three years from the date of infection. In Dr Adelstein's view it was likely that AT was infected with the virus some time prior to January 1992.

139 On the evidence it is entirely possible that AT had been HIV positive for a much longer period than the three years prior to November 1994 referred to by Dr Adelstein in the course of his evidence. That was, having regard to the cell count, the minimum period of probable infection in the doctor's view. I consider that AT had been infected with the virus not later than November 1991. Having regard to the evidence of Dr Furner as to the window period with respect to seroconversion and the detection of infection I consider that HIV antibody testing carried out on AT in the period from 1 February 1992 to 15 January 1993 would have revealed his positive status.

Did BT contract HIV as the result of sexual contact with AT and, if so, when?

140 BT gave evidence, which I accept, that she had only had sexual intercourse with three persons as at the time she was living in a domestic relationship with AT. She had sexual intercourse with the man who was the father of her first child. Subsequently, she had married an Australian man and lived for some years with him in Australia. Sexual relations between the two of them came to an end in mid-1991. She had not had sexual relations thereafter until forming her relationship with AT. In her home country she had, apart from the relationship with the father of her first child, engaged in intimate contact with two young men falling short of sexual intercourse. The latter explains the reference in one of the histories to her having five sexual partners. It appears that practitioners working in the area of sexual health include in a sexual history risk assessment episodes of intimate contact falling short of intercourse (T 56).

141 BT had no history of risk behaviour in terms of contracting HIV. She commenced a sexual relationship around Easter 1992 with a man who at that time was HIV positive. I accept that BT became infected with HIV in consequence of sexual contact with AT. It was not submitted that I would find otherwise.

142 For the reasons explained by Professor Stewart in his report it is not possible to say with certainty when BT contracted the virus. Her antibody positive status was determined on 8 March 1994.

143 On 22 February 1993, BT saw Dr Salgo at a time when she had a high fever and a sore throat. At that time she gave an account of having had the fever for "a few days". It was her evidence that she had not previously experienced flu or a flu-like illness. Dr Furner noted that the history given to her of the illness in February 1993, shortly described as a "severe flu-like illness", was a "probable seroconversion illness" (T 77). In this regard the doctor appears to have considered as significant the circumstance that BT had not experienced other flu-like illnesses to this degree on any other occasion. At the time of expressing the view that the February 1993 history was of a probable seroconversion illness Dr Furner had access to BT's CD4 cell count from the initial occasion in March 1994 and on subsequent testing. The opinion was expressed in a report of 4 July 1996.

144 Dr Adelstein said that seroconversion is an illness. When a person is infected with HIV it is the illness associated with their move from the negative antibody status to the positive status. It is itself a positive infection and is associated with the change in status. He was asked if there were any classic or common symptoms to seroconversion illness. He explained that it has symptoms similar to any other viral infection but that it "... is often described as the worst viral infection anybody has had. It can be associated with swelling glands, but it frequently is more severe than your average flu, although it is often confused with other viral infections" (T 27).

145 In evidence Dr Furner made reference to the difficulties in diagnosing seroconversion illness arising out of the fact that it can mimic other illnesses, particularly influenza (T 64).

146 I consider that the illness suffered by BT for which she saw Dr Salgo on 22 February 1993 was a seroconversion illness. Dr Adelstein was asked if there is a commonly understood period between infection and seroconversion. He said that it is usually between seven days and twenty-one days, somewhere around that range.

147 Dr Furner gave evidence that a review of the literature indicates the time from exposure to HIV to the onset of acute clinical illness (I took this to be a reference to the seroconversion illness) is typically two to four weeks although the range would be six days to six weeks (T 63).

148 It should be noted that not every person who contracts HIV undergoes a seroconversion illness.

149 At the time of consulting Dr Salgo, BT had been experiencing flu-type symptoms for "a few days". This might take the onset of the illness back to, say, 18 February 1993. That would mean, on Dr Adelstein's evidence, that the probability is that BT contracted the virus some time between 28 January and around 11 February 1993. On Dr Furner's account that the typical interval between infection and seroconversion is two to four weeks, the date of infection might be taken back to around 22 January 1993. It is to be remembered that she put the range as being between six days to six weeks. The date of infection could have been as early as 7 January 1993. The latter view seems unlikely having regard to Dr Furner's review of the literature and Dr Adelstein's evidence. Professor Stewart noted that the interval of six to eight weeks between the date when AT was reported to have visited a prostitute and the date of his febrile illness recorded in the defendant's notes was "an unusually long incubation period". The probability in my view is that BT contracted the virus on a date on or after 21 January 1993.

Would AT have undergone an HIV test if counselled to do so?

150 The defendant could not compel AT to undergo an HIV antibody test. A sample of AT's blood for the purpose of HIV antibody testing could only be taken with AT's consent.

151 Dr Law agreed that individuals who do not perceive themselves to have a likelihood of being infected are more likely to be reluctant to undergo testing (T49).

152 In Dr Furner's experience 95% of patients properly counselled will undergo an HIV antibody test.

153 Dr Fisher was cross-examined concerning this aspect (T.154):

"Q. Now I gather your experience as a general practitioner would tell you that sometimes, notwithstanding your best efforts, patients will not agree to undertake particular tests?

A. Yes. There is that possibility, yes.

Q. And particularly so if it is something like HIV and the patient has a perception that they are at low risk of acquiring the HIV?

A. That is true. I must say that in my experience I don't have a lot of problem with people who deny or who refuse to have HIV tests, but that is just my own experience.

Q. Nevertheless you are aware, aren't you, it is certainly well published, that often notwithstanding counselling, people will still refuse to undertake testing?

A. Yes, at times.

Q. And you would associate that refusal with a well-known and commonly observed factor in general practice, of a denial mechanism, use of a denial mechanism by a patient?

A. Yes, well that needs to be explored, of course. I agree with your proposition that it is a denial mechanism, but often it is the fear of truth or the fear of the unknown which governs it, and I believe that a special time should be devoted to people like that in order to ensure that they are well informed.

Q. And sometimes that special time works and sometimes that special time doesn't?

A. Occasionally it doesn't, yes.

Q. You said that from time to time, although not often in your experience, patients will refuse to have an HIV test notwithstanding counselling and advice?

A. That's right, yes."

154 Neither Professor Stewart nor Dr Gray expressed an opinion on this aspect.

155 After BT learned of her own positive HIV status she suggested to AT that he undertake an HIV antibody test:

"Q. Did you not repeatedly tell AT that he should ask his doctor to do a HIV test on him and he kept reassuring that this was not necessary?

A. I did not say repeatedly, but I remember I ask him once but when I ask him that question I said, `What about second opinion from a different doctor or having HIV test?' But he said, `Okay, I'll try'. That's all. But not I been asking him many times about it because -

Q. You certainly asked AT to go and have a HIV test, didn't you?

A. Yes.

Q. After you learned you were HIV positive?

A. Yes.

Q. He told you when you asked him that he did not think it was necessary, didn't he?

A. He doesn't say that it was necessary. He did not say that word. He said he will go and see a different doctor." (T 128C)

156 She was further examined on this topic and said:

"Q. You wanted your husband AT to have a HIV test?

A. Yes, and he said he wouldn't have one. He said he will go and ask a doctor, a different doctor.

Q. Which doctor?

A. I don't know. Because when I ask him, `What about have a HIV test?' he said, `Okay, I will find a second opinion. I will get - I will try. I will try and get a test." (T 132).

157 The conversation in which BT suggested to AT that he might undergo an HIV antibody test must have taken place on a date some time after 8 March 1994. That was the date on which BT was advised of her own positive HIV status. At that date AT was no longer a patient of the defendant. It was BT's evidence that on occasions AT told her he had consulted Dr Salgo. BT gave an account of one occasion when she and AT jointly attended Dr Salgo. As I understood her evidence this was an occasion when she went to see Dr Salgo, accompanied by AT, in connection with her own health problems. She went on to explain that they had talked to Dr Salgo about problems he, AT, was having in connection with his Hepatitis (T 128B). Dr Salgo's notes suggest this consultation took place on 9 July 1994. He records a discussion concerning AT for one hour concerning problems related to "Hep B cirrhosis". It was BT's evidence that it was on the occasion of this consultation that she and AT had "decided to have a second opinion" (T 128B).

158 It appears that following the 9 July 1994 consultation with Dr Salgo BT and AT spoke of the need for AT to obtain a second opinion. In the course of this discussion BT suggested that AT might have an HIV test. AT's response appears to have been to indicate that he would obtain a second opinion. The evidence does not establish that he did so.

159 The defendant submits that AT was not a person who exhibited concern for his health and wellbeing. In this respect reference is made to the final consultation at which the defendant referred AT to Dr Bye, Gastroenerologist. At this time AT had been informed he had cirrhosis of the liver. There is no evidence that AT followed up on that referral. Ultimately during 1994 the evidence shows he was attending Dr Salgo and that he did attend for consultations with specialists in connection with his liver condition. However, there was an interval of approximately one year before this occurred. Why would I consider that a man who did not pursue a referral to a specialist having been told he had cirrhosis would bother to follow up a recommendation that he have an HIV test?

160 The submission that AT was careless as to his health and generally a non- compliant patient needs to be evaluated, in part, by reference to the evidence as to his attendances both on the defendant and his subsequent general practitioner, Dr Salgo. AT was the defendant's patient for a period of fourteen months. During this time he attended for consultations with the defendant on eleven occasions. On the second visit the defendant arranged for a full blood count, liver function test and various other tests. AT returned twice in the next week in order to learn the results of the tests. On the latter of those visits, namely 1 February, it appears that the defendant ordered further tests and again asked AT to return to see the results of them.

161 On 10 February AT returned to see the defendant. That was the occasion when AT was concerned about a kidney stone. He asked for a referral in order to have it removed. The defendant considered that was not necessary and so advised AT. He told AT to return in two weeks time. AT returned a little over three weeks later although it appears his reason for seeing the defendant on that occasion may have been to obtain a medical certificate (he had been off work the previous week with fever, chills, aches and pains). The defendant told AT to return in two weeks time. AT complied with that request and returned for a further

consultation even though at that time (19 March 1992) he was feeling well. The defendant ordered further tests. It does not appear that AT returned to learn the results of the tests nor does the defendant suggest he instructed him to do so. However, it is clear that AT submitted to the tests since the defendant makes reference to receiving the results of them.

162 On 1 December 1992 when AT again consulted the defendant further tests were ordered. On 15 January 1993 AT was complaining, among other things, of abdominal pain and constipation. He was referred for a barium enema. It is clear that AT followed up on that referral since the results (showing spleenomegaly) were available at his next consultation on 22 January. On that occasion the defendant arrange for a CAT scan to investigate the spleenomegaly further. Again, it is clear that AT followed up that referral.

163 The defendant last saw AT on 30 January 1993. He says that on that occasion the CAT scan was suggestive of cirrhosis of the liver with portal hypertension and that he referred AT to Dr Bye for further management. AT's account is contained in paragraph 10 of his affidavit:

"In early 1993, Dr Oei told me I had cirrhosis of the liver. He told me he was satisfied, however, that the hepatitis condition was under control and I accepted this although my energy levels were still below normal".

164 AT gives no account of the referral to Dr Bye or the reason why he did not follow it up. The defendant's account of having made such a referral was not the subject of challenge. There is no evidence as to the receipt of any further medical advice or treatment by AT until 27 October 1993 when he attended on Dr Salgo to undergo an eye test to obtain a tourist bus driver's licence.

165 On 5 February 1994, AT consulted Dr Salgo complaining of afternoon tiredness and of being unwell. Dr Salgo appears to have had access to the results of AT's blood tests taken on earlier occasions at this consultation. Dr Salgo saw AT three days later and referred him to Dr Selby, a specialist, that afternoon. It appears clear that AT followed up on that referral. Throughout 1994 and continuing up until his admission to Royal Prince Alfred Hospital in February 1995 AT appears to have seen Dr Salgo regularly. It is also clear that he saw Dr Selby on a number of occasions between February and October 1994. This appears from the references in Dr Salgo's notes to progress reports from Dr Selby. In November 1994, AT saw Dr Koorey, another specialist. Dr Salgo's notes are consistent with a view that AT was attending to his health concerns as directed. It is clear both that Dr Salgo took blood from AT for test purposes and that he had submitted to tests as required by Dr Selby (notes of 7 October 1994 refer to letter from Dr Selby advising of results of further liver function tests).

166 On the evidence as to attendances on both the defendant and Dr Salgo it seems that AT was generally a compliant patient.

167 It happens, on occasions, that patients will refuse an HIV test after receiving competent advice. That, on the expert evidence appears a relatively unusual occurrence: Dr Furner report of 30/5/97 para 2 p.1; Dr Fisher at T 154. AT was willing to tell Dr Selby that he had had a sexual encounter with a Thai prostitute. As I have noted, he told BT about this episode on the occasion of their first meeting. Although he did not, in terms, refer to relations with a prostitute in his discussion with the defendant he did make reference to "casual exploits". These considerations do not lead me to think that AT was likely to be the relatively unusual

patient in denial who would steadfastly refuse testing even when the clear desirability of it was pointed out to him.

168 I do not consider the fact that BT suggested to AT that he have an HIV test (in the course of a conversation relating to his health status as he understood it, namely, that he was suffering from Hepatitis B and cirrhosis of the liver) is a useful guide to what AT might have done had the defendant adequately counselled him to undergo such a test as at December 1992. Any suggestion by BT who is medically untrained would not have served to bring home to AT the desirability of undertaking HIV antibody testing.

169 In November 1994 when Dr Koorey suggested that AT undergo an HIV antibody test he did so.

170 I consider that AT would have undertaken an HIV antibody test in 1992 had he been advised by the defendant that he should do so.

Would AT have taken appropriate steps to protect BT from contracting HIV from him?

171 I infer from the circumstances in which AT and BT met (in response to an advertisement placed in a newspaper) that both were interested in meeting a person of the opposite sex with whom they might be compatible with a view to a relationship including a sexual relationship. In this regard AT's hesitancy, after a number of outings, to permit a relationship to develop with a woman who already had a child seems an indicator that he was looking to meet a woman who met his criteria for an ongoing relationship.

172 At their initial meeting AT disclosed both that he was suffering from Hepatitis B and that he had engaged in sexual relations with a prostitute in a brothel. He also appears to have discussed the break-up of his earlier marriage. It is not clear to me that his reason for disclosing his Hepatitis condition was because of an awareness that it was sexually transmissible and that a prospective sexual partner should be on notice of that fact. BT's evidence in this regard is unclear. She said that she and AT had discussed the risk of sexual transmission of Hepatitis B but that there was "[n]ot much discussion when I first met him, but just when I was living with him" (T 126). Elsewhere, in the course of her evidence, she said that the two of them had not discussed the possibility of catching Hepatitis B through sexual intercourse in the period between their first meeting until AT told her he was HIV positive (T 132). The cross-examiner came back to this topic (T137) and BT agreed both that Dr Subbamma had told her of the risk of contracting Hepatitis B through unprotected intercourse and that she had discussed that with AT during the six month period that she was undergoing her vaccinations for Hepatitis B. Further, it was BT's evidence that they used condoms when AT was very sick and on occasions when he was complaining of not feeling well. When asked why condoms were used on such occasions she replied, "Because we said we have to protect each other. He said that" (T 171).

173 When, on one occasion, BT appeared to be denying that there had been any discussion with AT about the possibility of Hepatitis B being sexually transmitted, I considered that she was confused. Having regard to the whole of her evidence it seems to me that she was maintaining that there had been such discussions. Those discussions took place after she and AT commenced living together in September 1992. At the time of those discussions BT had been advised about the risk of sexual transmission of Hepatitis B by her own doctor. As I have already indicated, I accept that when the defendant informed AT that he was suffering

from Hepatitis B and noted (as AT confirmed that he did) that the likely source of transmission was sexual intercourse, the defendant gave him pamphlets including one relating to safe sex and that AT brushed the matter off saying something to the effect that he would not have the energy for sex.

174 AT and BT did not engage in sexual relations for some time following their initial meeting. They went out together on a number of occasions prior to any intimate contact. When they travelled together to Young during the Easter holidays in 1992 they did not have sexual relations on the first day. AT was feeling unwell. They had intercourse on the second day, for the first time, at a time when AT was feeling better. Thereafter they had sexual relations on three or four occasions between Easter and June of 1992. On those occasions no condom was used. BT had not at that time been counselled by Dr. Subbamma in relation to the risk of Hepatitis B infection. Such advice as the defendant had given to AT had not resulted in precautions being taken. Even after BT was advised of the risks by Dr Subbamma, and before she had completed her course of Hepatitis B vaccinations, the couple did not always use condoms (T 126). Condoms were used on occasions when AT was not feeling well. When AT was feeling well, but during the period prior to January 1993 when BT received her final injection to immunise her against Hepatitis B, they had sexual relations without condoms. BT explained it in this way:

"If I didn't use condoms, because he was very active and energetic on the certain times when we are not using condoms, well what I understand, for the condom is because we do some time, our sexual thing is not in the bedroom" (T 171).

I took this to mean that on occasions when AT was feeling well and the couple engaged in sexual relations in spontaneous circumstances they did not take heed of the warning to use condoms to protect BT from the possible contraction of Hepatitis B.

175 It should be noted that in his affidavit AT stated that it was not until mid-1994 that Dr Salgo advised him and his wife that Hepatitis B could be transmitted by unprotected sexual intercourse and that since that time they had not engaged in sexual intercourse. I do not accept that account. As I have already noted, BT was aware in mid-1993 of the risks of sexual transmission of Hepatitis B and I am satisfied that she discussed that matter with AT. This was a year before the joint consultation with Dr Salgo.

176 BT states that she and AT stopped having sexual intercourse after he was diagnosed as HIV positive. That was a matter of weeks before his admission to Royal Prince Alfred Hospital on the last occasion. Prior to that in the period between March and late November 1994 the two engaged in sexual relations. At that time BT knew that she was HIV positive. She said that they used condoms on those occasions because of her awareness that she was already sick with HIV. She insisted that they had always used condoms after she found out her status.

177 On behalf of the defendant, among other things, it was submitted that I would take into account the circumstance that BT had failed to disclose her HIV positive status to her husband and had continued to have sex with him following the discovery of it. Those circumstances do not seem to me to bear relevantly on a consideration of the causation issues raised by BT's claim. I should observe that I accept that BT was sure in her own mind that the source of the infection with HIV in her case was AT. I consider that she blamed AT for infecting her and had, as her primary focus, concern for the future well-being and financial

security of her son. She did not disclose her status to AT because she feared he may not marry her. Given her confidence that he was the source of her infection, I do not consider much turns on this aspect.

178 Given the couple's imperfect understanding of safe sex practices and their apparent willingness to engage in intercourse in circumstances which put BT at risk of infection with Hepatitis B, might it be said that, had AT known of his status, they would have continued, on occasions, to engage in unprotected sexual intercourse? In my view they would not have done so. Hepatitis B, as things turn out, is far more readily transmitted by sexual contact than HIV. It is a debilitating and dangerous condition. However, I do not think it reasonable to assume that the same fear attended the risk of contracting Hepatitis B in 1992 and 1993 as attended the risk of contracting HIV.

179 AT asserted in his affidavit that, had he been aware of his HIV positive status, he would not have had unprotected sexual intercourse with his wife. Little, if any, weight can be accorded to this assertion for the reasons explained by Kirby P in Ellis v Wallsend District Hospital (1989) 17 NSWLR 553 at 560.

180 AT was aware that his Hepatitis B had likely been contracted as the result of sexual contact. He appears to have had some understanding that the use of condoms can prevent the spread of sexually transmitted disease. Yet the couple did not always use condoms during intercourse. AT's understanding of safe sex practice was limited. It is to be borne in mind that he did not know he was infected with HIV. Drs Fisher and Law were of the opinion that providing a patient with pamphlets was not a sufficient means of discharging the practitioner's obligation to advise as to safe sex practices. Dr Law emphasised that the giving of pamphlets is not a substitute for the supply of oral information weighted to the patient's situation (report p.2). In evidence she referred to the need to ensure a patient understands the risks and the means of the practitioner checking that this is so (T 51).

181 Had AT known he was HIV positive and had he received adequate counselling concerning the transmission of HIV and safe sex practices would he have taken measures to protect BT from risk of infection? The expert evidence strongly suggests that he would. Dr Furner, whose expertise in the area of dealing with people who are HIV positive I accept without reservation, stated that it is generally accepted that a very high percentage of persons (of any sexual orientation) if adequately counselled will both notify their sexual partner and change their sexual practices so as not to place their sexual partner at risk.

182 I consider that BT became infected with HIV in January or February of 1993. By that time the couple were living together in a domestic relationship and, whatever their difficulties, had developed affection for one another. BT's evidence of AT's response when he first became aware of his own HIV status speaks of that. In the light of the expert evidence and having regard to the circumstance that AT and BT were in a stable relationship, I accept that AT would not have engaged in unprotected sexual intercourse with BT had he been aware of his HIV status.

183 I therefore find that had AT been appropriately counselled as at December 1992 he would have undergone an HIV antibody test. Such a test would have shown he had contracted HIV. Proper advice would have brought home to him the need to protect his partner from risk of infections and the means to do so. The couple would not have engaged in unprotected sexual relations thereafter. In the event, unaware of his HIV condition on an occasion

between late January and mid February 1993, the couple engaged in unprotected sexual intercourse and BT thereby contracted HIV. The defendant's negligent failure to properly advise AT with respect to a possible diagnosis of HIV and the need for an antibody test materially contributed to the plaintiff's infection with the virus.

184 Accordingly there will be a verdict and judgement for the plaintiff in respect of her personal claim.

The Claim Made on Behalf of AT's Estate

185 The negligence relied on in support of the claim brought on behalf of the estate of AT is the same as that pleaded in respect of the palintiff's personal claim.

186 The damages claimed on behalf of the estate of AT are for emotional distress, anxiety, depression and nervous shock.

187 The claim in respect of general damages made on behalf of the estate of AT survives the death of AT given that his death is not said to have been caused by the tort complained of: s 2(2)(d) of the Law Reform (Miscellaneous Provisions) Act 1944.

188 The claim made on behalf of the estate of AT is as to the injury he suffered, in the way of depression and/or nervous shock, on learning that he had unwittingly infected his wife with HIV. No evidence was led to suggest that AT's reaction was other than a normal grief reaction in all the circumstances. There was no expert evidence that AT had sustained any recognisable psychiatric injury. The only evidence touching on this issue was the statement in the affidavit sworn by AT on 23 February 1995: "I have been deeply depressed at the thought of having infected my wife with this deadly virus". BT described AT's evident concern for her welfare when he became aware of his HIV status. He apologised to her and became more affectionate and he told her, for the first time, that he loved her. BT was asked about her observations of her husband's mood after the occasion when he accompanied her to Dr Salgo's clinic when he learned that she, too, was HIV positive. She said:

"He just have, like have a deep breathing like, breathing like sometime you can't say it in words any more and every time he bumped me in the house he just give me a big hug and that's it, we can't say a word if we cannot ..." (T 115).

BT went on to describe how AT had told her that they had to look after one another and help one another from there on. BT's evidence concerning AT's mood and response to learning of his own HIV status and then being made aware of BT's HIV status is consistent with a view that he sincerely cared for her. No doubt he experienced feelings of sorrow and distress when he became aware of his wife's condition. The evidence does not disclose an injury or illness for which damages are recoverable: Jaensch v Coffey [1984] HCA 52; (1984) 155 CLR 549; Swan v Williams (Demolition) Pty Ltd (1987) 9 NSWLR 172.

189 In the light of the above findings there must be a verdict for the defendant in respect of the claim brought on behalf of the estate of AT.

Damages

190 The parties were in substantial agreement as to the appropriate measure of damages with respect to the plaintiff, BT's, claim for pecuniary loss. That agreement was set out in a schedule the relevant portions of which are reproduced below.

191 I was informed that the figure nominated in the schedule for future medication was a conditional one. As at present the plaintiff is not incurring significant expense in respect of medication. Once she obtains judgment she will be required to pay the commercial cost of pharmaceuticals. Mr Menzies QC, who appears for the plaintiff, indicated that he may wish to lead evidence on this aspect in the event that the parties were not able to reach agreement on an appropriate figure as to the costs of future medication. I have not been advised that the parties have reached any such agreement. Accordingly I will hear submissions and receive any further evidence on this issue prior to judgement being entered.

Schedule

1. Out of pocket expenses $ 5,000

2. Past economic loss $350 wk from 28/2/97 $ 41,650

Superannuation $ 2,704

3. Past care

Jan 97 - 7hrs wk -CSN

27 July 97 10 hrs wk domestic assist $38,612

estimate 1/3 rel to asthma disability and

complication $12,870 $ 25,742

4. Future care

(life expectancy - 10 yr period from

infection and 15 mnth

life expect after i.e. to 30/3/04)

$223,421

5. Future medical treatment

regime for 5 yrs

i.e. to March 2004 + 3 months $ 8,053

6. Future medication

$600 mnth - subject to showing a/cs

and frequency of dosage

$138.64 x 5 yrs (NB Conditional) $ 33,634

7. Future hospital

As in assessment - 5 yrs $ 11,663

8. Future economic loss

5 yrs @ $371 wkly $ 90,000

Loss of expected income

Mid 2004 to age 65

= 22 yrs deferred $193,662

less 35% keep $ 67,781 $125,881

192 The agreement with respect to the pecuniary loss items did not include interest with respect both to past economic loss (item 2) and past care (item 3). This matter was drawn to my attention. However, it was not suggested that there was any issue as between the parties concerning it. I propose allowing the sum of $ 9,300 by way of interest calculated in accordance with half the rate as specified in Schedule J for the period 28/2/97 to the date of judgement.

193 This leaves a consideration of the question of general damages. I consider that the plaintiff is entitled to a significant award with respect to general damages. She was aged 33 years when she learned that she had contracted HIV. Despite some improvement in the outlook for those suffering from HIV/AIDS the prognosis for BT remains guarded. Her life expectancy is agreed to be some ten to eleven years from the date of diagnosis. She faces spending that relatively lengthy period both knowing of her condition and its probable unpleasant course.

194 BT's pain and suffering to date has been considerable. She has experienced significant AIDS related conditions. In January 1997 she suffered weight loss, diarrhoea, severe fatigue, oral candidiasis and hair loss. As at that time she had a low CD4 cell count indicative of a severe degree of immunosuppression. She was commenced on antiretroviral therapy. In early 1997 her prognosis was said to be extremely uncertain and there were fears that she would progress to AIDS within two years. At that time BT appeared not to be responding to treatment. She continued to suffer from diarrhoea and developed a facial rash together with other side effects of the drug therapy. She experienced extreme emotional distress in relation to the rapid progress of her illness and the associated poor quality of life. In May 1997 she was commenced on anti-depressant medication.

195 The position has since improved in that BT has responded to the antiretroviral therapy and her CD4 cell count has increased. However, she nonetheless had what Dr Cooper describes as a "stormy course" in the year preceding this trial.

196 I consider an appropriate award of general damages to compensate BT for her pain and suffering, loss of amenities and loss of expectation of life to be $160,000. I apportion this 35% as to the past and 65% as to future loss.

197 In the light of the foregoing my orders are:

(1) Verdict and judgment for the defendant in respect of the claim brought by the plaintiff in her capacity as administratrix of the estate of AT.

(2) Verdict for the plaintiff in respect of her personal claim against the defendant, judgment will be given in the sum of $703,414.00 together with such additional sum, representing future medication costs and interest on past non economic loss, as may be agreed or determined.

(3) The defendant to pay the plaintiff's costs of her personal action.

I will hear any evidence and submissions from the parties on the question of the quantum of damages for future medication costs and the date from which interest is to commence in relation to past non-economic loss. In the event the parties are able to reach agreement as to these matters short minutes may be brought in and judgment entered in accordance with these reasons.

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