Harvey & 1 Ors

v.

PD

Supreme Court of New South Wales
14 October 2003, 30 March 2004
(2004) 59 NSWLR 639; [2004] NSWCA 97
Spigelman CJ, Santow and Ipp JJA

1 **SPIGELMAN CJ:** In this matter I have had the benefit of reading the judgments of Ipp JA and Santow JA in draft. Their Honours set out the facts, issues and submissions. Subject to the following observations I agree with the judgment of Santow JA in the appeal.

2 The trial judge found a number of breaches by Dr Harvey, for whom Dr Chen was vicariously liable, and by Dr Chen. Like Santow JA I have come to the conclusion that it is unnecessary to determine whether or not a number of matters that arose after the initial consultation, including all those that directly involved Dr Chen, constituted a breach of any duty and, if so, whether such breach caused any damage to the Respondent.

3 I agree with Santow JA that the subject matter of the initial consultation and the fact that it was a joint consultation for the stipulated purposes meant that it was incumbent upon Dr Harvey, in the light of his knowledge of ethical requirements, patient confidentiality and s17(2) of the *Public Health Act* 1991, to advise FH and PD of the need for each to consent to the supply of their results to the other. His failure to do so led to the damage suffered by PD on the basis that if FH had agreed, she would have been fully informed of his HIV status and if FH had not agreed, she would have terminated the relationship. These findings of fact were plainly open to his Honour. Indeed, they were right.

4 Of the other inadequacies which Cripps AJ identified, and which he found to constitute breaches of duty, I agree with Santow JA that it is unnecessary to express a final view. However, I am not convinced that the findings as to defective record keeping were correct or that any inefficiency in that regard was causally linked to any damage. In particular, I am not satisfied that there was any breach that arose by reason of the failure to link the fact that PD, in subsequent visits to the practice, had intended to visit Ghana, suggesting a continuation of her relationship with FH notwithstanding his positive HIV status, with her request for prescription for a contraceptive pill, indicating an intention to have unprotected sex and that FH had either not informed or had deceived PD about his HIV status. However, it is unnecessary to decide these alternative findings of breach.

5 Ipp JA would uphold the Notice of Contention and conclude that Dr Harvey breached a duty to inform PD of FH's results. I note that FH's results were positive for Hepatitis B as well as HIV. The former is not a Category 5 condition and, accordingly, is not subject to the restriction on disclosure by s17(2) of the Act. However, no reliance was placed on this factor.

6 The approach of Ipp JA requires a finding that there was "tacit consent" to disclosure by FH. I accept that a consent under s17(3)(a) may be oral or in writing. The issue, however, is whether it must be express or can be inferred from conduct.

7 This is a matter of statutory construction. Section 17(2) creates a criminal offence. The statutory obligation is framed in terms of a positive obligation to take steps to prevent disclosure, rather than in terms of a negative obligation not to disclose. Further, it is not limited to revelation of results, but extends to disclosure of the fact that a test has been or will be conducted.

8 The public policy underlying this strict regime is to ensure that persons are not deterred from submitting to tests by reason of an apprehension that the fact of being tested or a positive result may be disclosed. This purpose is, in my opinion, best served by minimising the potential for disagreement on the provisions which exclude liability.

9 I am, for this reason, inclined to the view that a "consent" for purposes of s17(3)(a) of the Act should be express. However, as I have concluded that there is an alternative basis for liability, I do not need to express a final view.

10 As to the cross-claim, I agree with Ipp JA, subject to two observations.

11 First, the two limbed test for causation, which his Honour applies, is apt in the circumstances of the case. I wish to reserve my position on its more general application.

12 Secondly, on the normative issue I am content to rest the conclusion on PD's informed decision to have a second child. I do not find it necessary or appropriate to give weight to the other factors to which Ipp JA refers.

13 **SANTOW JA**:

INTRODUCTION

The appellants, Dr Harvey and Dr Chen appeal against the decision of Cripps AJ. The trial judge concluded that in breach of their professional duty to the respondent "PD", they failed to take sufficient steps to cause her to be apprised that her future husband ("FH") was HIV-positive when FH had deliberately deceived her into believing that he was not. PD and FH had attended a joint consultation for the purpose, as understood by Dr Harvey who saw the couple together, of having blood tests to ensure that neither carried the Human Immuno-deficiency Virus (HIV) or any other sexually transmitted disease. Dr Harvey knew this was required because they were proposing to get married. He also knew that PD had particular concern about the STD status of her future husband because (as the patient record noted) he came from Ghana. She believed there was a higher risk that a person from Ghana would be HIV positive than one from Australia. FH's deception of PD occurred after PD received her results. She received them not from their doctor at a further joint consultation – none had been

advised – but from the clinic's receptionist, who told PD she was not entitled to receive FH's pathology report, which she had requested in view of the earlier joint consultation, but only hers.

14 The focus of the appeal was first on deficiencies in the pre-test counselling and on advice given and omitted to be given by the appellants. The omissions included failing to advise that in the absence of consent, Dr Harvey was legally prohibited from disclosing any information concerning HIV or AIDS status of one to the other (under s17(2) of the *Public Health Act* 1991 (NSW)). He also omitted to raise whether the test results were to be conveyed at a further joint consultation or separately.

15 Second, the appeal focussed on the advice and counselling given and omitted to be given to FH **after** the result of the test was known. This was when PD's partner was found to be HIV positive but not PD. I set out below those deficiencies found by the trial judge in the medical advice to FH, and in follow-up after the discordant test results were known:

(a) Dr Harvey did not raise with FH any issue arising out of the joint consultation and in particular asked no questions concerning whether FH was proposing to tell PD the result of his tests;

(b) Not until May 1999 was any check made to determine whether FH kept his appointment with the Royal Prince Alfred Hospital Immunology Clinic (RPAHIC) (Red, 21 at [19]);

(c) PD attended the appellants' clinic on 31 December 1998 for a contraception pill and on 11 February 1999 for vaccines; the results of the joint consultation was not adverted to directly or indirectly on either of these occasions (Red, 21 at [19]);

(d) Dr Chen's counselling of FH (found by the trial judge to fall far short of what was expected of a GP in the circumstances) consisted of the following:

    (i) told he had AIDS not HIV,

    (ii) told "it kills",

    (iii) told treatment was expensive,

    (iv) did not ask whether he would tell his partner about the illness,

    (v) assumed certain things because of FH's nationality and appearance (Red, 22 at [22]);

(vi) failing to recognise that people who hear this information often go into denial, often become angry, and not infrequently blame others (Red, 23 at [23]);

(e) Dr Harvey did not contact PD or FH in May 1999 when he received a questionnaire from the Department of Health seeking information about the HIV status of FH; at this time FH and PD were living together (Red, 24 at [26] but she was not to manifest any symptoms till around September 1999 and was found by the trial judge to have contracted the disease in August 1999;

(f) No attempt was made to contact PD or FH after it became known that FH did not attend the RPAHIC; on 15 June 1999 the Alpha Medical Centre received a letter from RPAHIC advising that it had no information that FH had ever attended the clinic;

(g) Sometime in February 2000 PD visited Dr Chen requesting details about FH; during this conversation Dr Chen told PD that FH was HIV positive (Red, 25 at [33-4]).

16 The appellants seek to invoke the statutory obligation to take all reasonable steps to prevent disclosure of test results without consent as placing a fundamental obstacle to attributing any responsibility to the appellants for the respondent's injury. They also contended that the deceit of the husband operated as a superseding event. Moreover, they contend that when the receptionist told PD, correctly, that she was not entitled to see FH's test results, this should have made it clear to her that she was not entitled to rely on the doctors for that information any longer; that is, if indeed (as the appellants deny) she had ever relied on them rather than FH for that information.

17 The respondent challenges that contention frontally. The respondent denies that this is a case about the duty of confidentiality of test results and when it can be breached. Rather, says the respondent, it is a case about the proper management of a couple who attend a doctor together for the known purposes of HIV testing prior to marriage and engaging in unprotected sex. It is also about the proper management of patients after they have been tested for HIV one of whom tests positive. The respondent relies on the finding of the trial judge that each of the doctors were negligent in their management of the situation that was presented to them. That negligence was evinced by their departure from, and ignorance of, established procedures which doctors are supposed to know and follow when dealing with HIV testing (Orange, 52, respondent's written submissions).

18 The respondent has filed a Notice of Contention in which two additional grounds are sought to be put for affirming the decision of Cripps AJ, namely:

(a) His Honour should alternatively have held that there was an implied waiver of confidentiality between the respondent and her former husband (FH), or

(b) His Honour should have found that upon the true construction of the contract between the respondent, FH, and Dr Harvey, there was an implied term of that contract that Dr Harvey would arrange for the blood tests and to advise the respondent of her results as well as the results of FH.

19 The Notice of Contention places particular reliance on the finding (at [48] of the judgment) that the trial judge was "*of the opinion that had the question arisen concerning what the parties* [the respondent and FH] *intended to do with the results when they got them, both would have said that the other could have access to them*". That is the basis put for there being an implied waiver of any confidentiality between the parties.

20 The respondent brings a cross-appeal on the ground that the trial judge "*erred in failing to award damages based on **Griffiths v Kerkemeyer** (1977) 139 CLR 161 and **Sullivan v Gordon** (1998-99) 47 NSWLR 319 in relation to the plaintiff's second child*" and "*in finding that 'a link must be established' before damages in the nature of **Sullivan v Gordon** could be awarded*".

21 Put briefly, the cross-appeal arises in these circumstances. The respondent after the termination of her marriage to FH, subsequently became engaged to a person also HIV positive, knowing of her condition. After taking such precautions as possible, she gave birth to a second child in 2002, who was not HIV positive. The damages relate to the costs of caring for that second child from the time (2014) when it was found by the trial judge that PD will be incapacitated by her disease, or deceased; that is to say from 2014 when the child would be 12, till the child's maturity at 18. The respondent seeks leave (should it be necessary) to re-argue the decision in *Sullivan v Gordon* (supra). This is to the extent that Beazley JA required a causal relationship between the defendant's negligence and the birth, though contending that, properly understood, Beazley JA's decision did not determine that such a connection was necessary. Beazley JA, it was said, in the face of a submission that the link although necessary was absent, found the causal link established; it was therefore unnecessary for her to determine whether such a causal link was a necessary condition to recovery.

OVERVIEW OF ISSUES

22 This appeal therefore raises a number of difficult questions, not so far directly dealt with at appellate level in Australia.

Statutory confidentiality and pre-test counselling

23 First, there is the effect of the statutory obligation under s17(2)(b) of the *Public Health Act* 1991 (NSW) ("the Act"), to take all reasonable steps to prevent disclosure of the test results, unless with consent. What was successfully pressed below as a critical fact was that the tests were undertaken pursuant to a joint consultation and for a purpose whose achievement depended on their truthful joint communication, most reliably achieved through disclosure at a further joint consultation. The question this poses is

whether that statutory obligation of confidentiality nonetheless by its constraints precludes any negligence on the part of Dr Harvey from his failing at the initial joint consultation to raise:

(a) the need for consent to disclosure,

(b) the manner of disclosure, or

(c) the possibility of discordant results.

24 The Act also raises questions of what the Act permits in the way consent to disclosure is to be obtained and what constitutes a valid consent.

25 There is a specific finding, potentially relevant to causation bearing upon what would have happened had these matters been raised. The finding was that had the question arisen as to what the parties intended to do with the results when they got them, both would have said the other could have access to them (judgment at [48] Red, 30).

Post-test counselling of FH

26 Then there was the perfunctory and inaccurate post-test counselling of FH. It poses the question, was the failure by either doctor to urge on FH that he disclose his positive test result to PD negligent, or was such a course justified if not mandated by the statutory obligation? The appellants emphasise that the statutory provision is not just an obligation to refrain from disclosure, but a positive obligation to take all reasonable steps to prevent disclosure.

27 It is contended by the appellants that, especially with the test result now known, such urging of FH (to disclose his positive result to PD) would have entailed the doctors breaching their statutory obligation not only to refrain from disclosure, but to take all reasonable steps to prevent disclosure.

28 The appellants put into contention not only the extent of any duty of care, but also whether the injury suffered by PD could truly be said to have causally resulted from any breaches by the doctors. They contend that FH's deception operated as a *novus actus interveniens*, superseding any causative role played by the doctors' negligence, if neglect there were. The appellants contend that had they given the advice and counselling, which the trial judge held should have been given, and whether before or after the test results became available, the injury would still have occurred. This is because FH's conduct showed that he would have ignored such advice and practised the same deceit on PD.

29 Then there is the question whether, in the post-test period, Dr Chen or Dr Harvey should have had a proper system of record-keeping and automatic shared access by all doctors to patient medical records within the medical centre which would have revealed that FH had not disclosed his positive status to PD. This it is said, should have been revealed when PD requested a prescription of an oral contraceptive pill and vaccinations for a trip to Ghana.

30 The appellants contend that in a multi-doctor medical centre it is unreasonable to base legal duties on the theory that every doctor has the knowledge of all of the others about the same patient. They then seek to deal with the matter on the basis that if, contrary to that submission, it would be reasonable so to base the doctors' duties in such a centre, still no liability would ensue.

31 The argument sought to be answered proceeded this way. Let it be assumed that the doctors followed up FH more vigorously than they did and had cross-referenced information. Let it be assumed also that they would from the prescription and vaccinations be on notice of his likely deceit or could verify it by a non-suggestive question of PD ("*were they still together*"). That question would need to be so framed as not to infringe the statutory duty of confidentiality. If PD responded that she was still in a relationship with FH, the doctors under the Act, knowing of the probability of unprotected sex from the contraceptive pills, could then notify the Director General.

32 But the appellants argue that the question at the end of that causal chain is whether the Director-General would have taken action having the practical effect of preventing FH continuing in his deceit with PD. The appellant analyses the evidence submitting that it pointed against any such intervention being likely.

PD's Cross-appeal for cost of child care for her second child after PD's anticipated incapacity

33 Finally, there is the difficult question posed by PD's cross-appeal and the further head of damage for care of the second child after PD's anticipated incapacity. It can be considered in causal terms. Did the doctors' negligent failure result in this further head of damage, or was it the result of PD's independent, and it is asserted, unreasonable act in having the further child, knowing that she was now HIV positive? Alternatively, what is the appropriate scope of liability or extent of legal responsibility in relation to each doctor's negligence?

34 Similar questions underlie that issue when framed in terms of an obligation to mitigate damage on the part of PD, or in terms of the proposition that "*recoverability of damages is always bounded by considerations of fairness and reasonableness*" (per Lord Nicholls of Birkenhead in *Rees v Darlington Memorial Hospital NHS Trust* [2003] 3 WLR 1091 at 1098 para 13 citing *Kuwait Airways Corporation v Iraqi Airways Co (Nos. 4 and 5)* [2002] 2 AC 883, 1090-1 paras 69-70).

SALIENT FACTS

35 Almost all the salient facts are undisputed. I have set these out below in summary form, indicating any difference between the parties. A more detailed elaboration appears in the judgment of Ipp JA under the heading "the relevant circumstances", when describing the initial medical interview, its earlier background and its immediate aftermath.

The trial and its result

36 Dr Harvey and Dr Chen were the defendants in proceedings brought against them by PD in the Common Law Division. PD claimed damages for personal injuries said to have been occasioned by breach of professional duty on the part of Dr Harvey and Dr

Chen in failing to take sufficient steps to cause her to be apprised that her future husband ("FH") was HIV-positive. The proceedings were heard before Cripps AJ who, on 10 June 2003, gave judgment for the Plaintiff against both Defendants, for $727,437. Dr Harvey and Dr Chen ("the Doctors") have appealed to the Court of Appeal from the judgment of Cripps AJ.

Initial joint consultation for HIV testing

37 PD was a patient of the Alpha Medical Centre at Marrickville ("the Centre") from October 1997 until February 1999. On 16 November 1998, she attended the Centre with her future husband for the purpose, as understood by Dr Harvey who saw them together, of having blood tests to ensure that neither carried the Human Immuno-deficiency Virus (HIV) or any other sexually transmitted disease, because they were proposing to get married. At the time of that consultation, PD and FH were not living together, but had a sexual relationship and practised protected sex. FH came to the Centre for testing at PD's request. Dr Chen was the medical director of the Centre, and he employed Dr Harvey on a regular sessional basis.

38 In the course of the initial joint consultation, Dr Harvey was told that FH came from Ghana. PD was concerned about the STD status of her future husband, because she believed that there was a higher risk that a person from Ghana would be HIV positive than one from Australia. While Dr Harvey did not concede that that accorded with his understanding, he did believe that a person from Ghana was at higher than usual risk of having other sexually transmitted diseases. Following that consultation, he made the following entry on PD's medical record:-

> 16.11.98 Low risk lifestyle
> Nil IVDU, no anal sex
> Wants STD check
> Investigation - HIV
> Hep B/RPR See 1/52 Dr Nick Harvey

39 On FH's card, he made the following entry:-

> 16.11.98 Low risk lifestyle
> Nil IVDU From Ghana
> About to engage in new relationship
> Counselled wants blood test for STD
> Talk about ... - Nil. Investigation HIV
> Hep B/RPR See 1/52

40 Neither card recorded the circumstance that the consultation was a joint one. PD's card did not record that she was proposing to enter a new relationship of marriage with, it can be taken, unprotected sexual relations replacing the protected sexual relations they had hitherto practised. Dr Harvey did not inform either PD or FH that, in the absence of consent, he was legally prohibited from disclosing any information concerning the HIV or AIDS status of one to the other. How the test results were to be dealt with was not discussed at all. PD believed – the trial judge found, "reasonably" - that she would have FH's results and he would have hers; but the topic was not raised. The trial judge found,

in accordance with evidence apparently given by PD, that she and FH had agreed to exchange pathology results; Red, 20H-M at [13].

41 I interpolate here that the appellants contend that this finding is not unimportant. They submit that, with the finding that how the results were to be dealt with was not addressed by Dr Harvey these findings combine to suggest that PD relied on FH - rather than on the doctors - for the provision of FH's results. That is disputed by the respondent. This is on the basis that the finding is at the least neutral on the matter, submitting that in fact the finding rather supports the inference the respondent seeks to draw to the effect of its Notice of Contention. That inference is that there was an implied waiver of confidentiality between respondent and FH. Also that there was an implied term in a tripartite contract that Dr Harvey would arrange for the blood tests and advise the respondent of her results as well as the results of FH.

42 Both PD and FH gave blood at the joint conference in the presence of each other, and left the surgery. Dr Harvey told them to return to his surgery in about a week's time when the pathology tests would be available.

43 On 23 November 1998, a week later, Dr Harvey received PD's pathology report, which was negative for both Hepatitis B and HIV. The following day, 24 November 1998, he received FH's pathology report, which was positive for Hepatitis B and HIV.

44 PD returned to the Centre sometime between one and two weeks after the initial consultation. The receptionist gave her a copy of the pathology report relating to her. She asked for a copy of FH's pathology report, but was told that it was confidential and could not be given to her. The receptionist did not make any mention that, with consent of FH it could be given to her. It was common ground at the trial that PD should not have received her result from the receptionist but from a medical practitioner (Red, 20D at [14]). She should have been told that the results were not necessarily definitive because of a "window" of three months prior to the test within which HIV could have been contracted without a positive result.

45 Following his receipt (1 day later) on 24 November 1998 of FH's pathology results, Dr Harvey made the following note in FH's record:-

> 24.11.98 Blood - HIV positive
> Unable to contact patient by phone. I have made appointment for immune clinic RPAH 9am Thursday 26.11.98
> Letter in notes Dr Nic Harvey

46 According to Dr Harvey, when he received FH's results on 24 November, he telephoned the Centre for FH's phone number. Despite what appears from the medical record, he said that he spoke to FH and made an appointment for him to attend the Royal Prince Alfred Hospital Immunology Clinic ("RPAHIC") at 9am on 26 November 1998. The trial judge accepted that evidence (Red, 21H-L). An appointment was indeed made for FH to attend RPAHIC on Thursday, 26 November 1998, although FH did not keep

that appointment. Although there was no copy of the letter in the medical record, the trial judge accepted that the appointment was made, but not kept (Red, 22K-L).

47 In the course of the telephone conversation on 24 or 25 November (Dr Harvey failed to have a face to face meeting with FH and should have done, Judgment Red, 33L-O), Dr Harvey told FH that he had "very bad news" and that he had tested positive. He thought FH seemed disbelieving of what he was hearing, but Dr Harvey told him that the laboratory was certain of the result. He told him that he had made an appointment for him to attend RPAHIC, and should take a positive attitude towards his condition because of the enormous advances recently made in treatment of people with that illness. FH asked: "*Does this mean I can't have children*?", and Dr Harvey responded: "*At this stage the answer is no*". Dr Harvey advised him not to have unprotected sex, and that he could not safely father a child. Dr Harvey did not ask whether FH was proposing to tell PD the result of his test nor did Dr Harvey seek consent for the Clinic or himself to make that disclosure to PD.

48 Dr Harvey did not see FH again. FH did not keep the appointment at RPAHIC. Nor did Dr Harvey ever speak to PD again, although she attended the Centre (where she saw a different doctor) on 31 December 1998 for a contraceptive pill, and on 11 February 1999 for vaccines, because she was travelling to Ghana on 31 March 1999, where she proposed to remain for a period of three weeks. Neither the joint consultation nor the test results were adverted to on either of those occasions, and it was not until after mid May 1999 that any check was made to determine whether FH had kept his appointment with RPAHIC.

49 Dr Harvey advised the NSW Health Department in June 1999 (three **months** before PD became infected) that "*more complete and accurate information*" on FH could be obtained from RPAHIC, though he already knew that FH never attended there and that they could not have any information on him at all (Blue, 273X, cross-examination of Dr Harvey, Black, 325V-328P).

50 Dr Harvey accepted that, had he looked at PD's patient history card after he became aware that FH had not attended the appointment at RPAHIC, and had seen that she had attended for oral contraception and vaccination for a trip to Ghana, he "*possibly would have thought*" that they were in a continuing sexual relationship (Black, 328T-329D) and would have made further inquiries of either PD or FH – because it would have been a matter of "*paramount concern*" that PD was in danger of infection.

51 Despite a submission on behalf of PD to the contrary, the trial judge also accepted that Dr Chen spoke to FH at the time of handing him the letter of referral to RPAHIC, and on that occasion urged him to attend RPAHIC (Red, 22V-Y). However, His Honour found that the advice given by Dr Chen "fell far short of what was expected of a general practitioner in all the circumstances". In particular, he told FH that he had AIDS (which he did not); he told him: "It kills", which the experts agreed was inappropriate; he said FH appeared to understand and shook his head, but thought that he appeared to accept the news. FH raised the question whether treatment was expensive, and was told that it was. Dr Chen said that he formed the view, but without having raised or discussed it with FH, that FH understood his responsibilities and would probably disclose his HIV status to his sexual partner - whose identity Dr Chen did not know. Dr Chen's rationale for this

assumption was that FH was a neatly dressed man who appeared to be educated and who - because he was of African origin - would presumably know what HIV was and its basic nature.

52 The trial judge inferred that the reason why Dr Chen did not raise with FH the question of disclosure to his sexual partner was that he did not know who that partner was - let alone that she, PD, was a patient of the Centre. The treatment record card in the case of both PD and FH did not record the fact of the joint consultation, or that PD was about to enter a new relationship (with FH or otherwise) (judgment, Red, 19L-P, 44H-J) Dr Chen's evidence was that he never even knew PD existed, although he did read FH's medical records and would have seen there that FH was in a new relationship about which he asked nothing. The trial judge concluded that Dr Chen's "counselling" of FH fell far below that expected of a general practitioner, expert evidence on both sides being to the effect that when a GP is conveying grave information concerning life threatening diseases, it is notorious that the recipient although perhaps understanding what has been said, does not fully absorb the consequences, frequently goes into denial, often becomes angry, and not infrequently blames others. Dr Chen, the trial judge thought, apparently recognised none of these matters and thought that having referred him to the RPAHIC he had discharged his duty to FH and did not think that there was any need to check with RPAHIC to see whether FH kept his appointment (judgment Red, 22W-23T).

Deception of PD by FH

53 After PD was refused access to FH's record, she telephoned him and told him she had tested negative. He said that he had tested negative also. He said that he did not wish to see her results, because he accepted her word; she, however, said that she wished to see his results. A few days later, she went to his home and was shown what he represented to be his pathology results, and showed him to have tested HIV negative and Hep B negative. This report was either a forgery, or fraudulently obtained. PD did not keep a copy, and returned it to FH.

54 At the time of the consultation in November 1998 and for some months after, PD and FH continued to live apart, and did not have unprotected sex. They visited Ghana in about March or April 1999, and afterwards commenced living together and engaging in unprotected sex. They married in July 1999, and had a child born on 28 February 2000.

PD visits clinic again

55 On 31 December 1998 PD visited the clinic for oral contraception (Blue, 240) while on 11 February 1999 PD attended the practice for vaccination for a proposed trip to Ghana in March 1999 (Blue, 241). No-one connected these facts or drew any conclusion that she was probably having unprotected sex with her Ghanaian partner, FH. Both dates were before May 1999 when PD and FH commenced cohabitation and September 1999 when PD experienced the first symptoms of a sero-conversion illness, i.e. an HIV infection. With proper record-keeping, the likelihood that she was having unprotected sex with her partner FH should have been identified. But, as the trial judge found (Red, 42R-T) "*From the time PD and FH left the surgery after giving blood on 16 November 1998 they were treated by the practice as two separate and unrelated patients – in circumstances where Dr Harvey knew that was not so and Dr Chen ought to have known it was not so*".

The Centre receives further information

56 Sometime in May 1999, Dr Harvey received a questionnaire from the Department of Health, seeking information concerning FH's HIV status, which had been notified to the Department by the serum laboratory (which is required by law to provide such information to the Director-General of Health). Neither FH nor PD, who were then living together, were contacted by Dr Harvey; the trial judge did not accept Dr Harvey's evidence that an attempt to contact FH was made at that time.

57 On 15 June 1999, the Centre received from RPAHIC a letter advising that it had no information that FH had ever attended, although its records confirmed that an appointment had been made for him on 26 November 1998. No attempt was made by the Centre to contact PD or FH, the trial judge inferred because the practice considered that it had no further obligation to either. His Honour added that Dr Harvey considered that he had no further obligation to PD after she was given her results by the receptionist and told she was HIV negative, and no further obligation to FH after writing the letter of referral to RPAHIC.

PD contracts HIV

58 In September 1999, PD (already pregnant) was admitted to Canterbury Hospital, with a fever and a rash. This was later recognised as a sero-conversion illness indicating that probably she had become HIV positive. She became aware FH was HIV positive when she found a copy of the genuine pathology report among his papers at the end of 1999 or early 2000. Before she became aware that she was HIV positive, PD attended at the Centre and spoke to Dr Chen, demanding to know why she was not told of her husband's HIV status. A note was made by Dr Chen of that consultation in FH's records, as follows:

> (Chen addendum) Patient came (wife) requesting records and info about husband. Explained clearly husband may be unwell - confidentiality issues apply - need to take precautions and advise husband to attend here or any doctor for r/v ASAP, if still has not resolved last 1-2 years issues. Explained records cannot be given to her. Attend with husband to resolve issues best options.

59 Dr Chen said that when he spoke to PD, she told him that she was HIV positive and wanted to see the test results of her husband; he said he would not give them to her because he did not have FH's permission (although he did, to some extent, discuss the results with her); he said that he asked them both to attend together, so that he could get permission to discuss the issue, and that if she believed she was HIV positive, she would need to take precautions. PD said she did not know she was HIV positive when she visited Dr Chen sometime in January or February 2000. She made an almost contemporaneous note of the conversation, and the trial judge accepted her version. Shortly after this meeting, in January 2000, just prior to the expected birth of her child, PD had a further test and found she was HIV positive.

60 The trial judge found that the appellants breached their duty of care to the respondent in nine material respects.

(i) by failing to discuss with PD and FH at the initial consultation the method by which they wanted to receive their results given the distinct possibility of a discordant result (Red, 32T-33K);

(ii) by causing and/or permitting a receptionist in the practice, rather than a medical practitioner, to convey PD's test results to her (Red,20N);

(iii) by failing to provide pre-test counselling to PD and FH according to the guidelines imposed by the Health Department (Red, 35H-36F);

(iv) by conveying to FH his test results by telephone rather than in a face to face consultation with a medical practitioner (Red, 33L-O);

(v) by failing to provide adequate post-test counselling to FH, especially in relation to his obligation concerning disclosure to sexual partners (Red, 33N-P; 38T-39Q);

(vi) by failing to ask FH whether he intended informing PD of his condition (Red, 38T);

(vii) by failing to follow up the referral of FH to the Royal Prince Alfred Hospital Immune Clinic (Red, 39S);

(viii) by failing to record upon the treatment record card of either D or FH the fact of the joint consultation or that PD was about to enter a new relationship (Red, 19L-P; 44H-J);

(ix) by failing to take fairly obvious steps designed to make PD aware that she was exposed to the danger of infection at a time when the appellants knew or ought to have known such was the case (Red, 42A-E; 44A-J);

61 Cripps AJ found that had one or more of these things been done, it would have led to PD learning of FH's HIV infection (Red, 41N). But the doctors did nothing at all.

62 Turning to the judgment of the trial judge, a fair summary of that judgment, taken substantially from the appellants' careful summation, is as follows:

(i) Dr Chen (as employer) was vicariously liable for the acts of those whom he employed, including Dr Harvey (judgment Red, 30D-G);

(ii) Although PD was plainly of the opinion that she was entitled to FH's results, and he had consented to her having them before the joint

consultation with Dr Harvey, FH did not give his consent to Drs Harvey and Chen to disclose his results to PD (judgment Red, 30J-S);

(iii) The initial joint consultation was inadequate, because no reference was made to what would happen if the results were discordant, bearing in mind the obligations of confidentiality (judgment Red, 32T-33J). The prospect of discordant results, although unlikely, was not wholly remote in the circumstances (judgment Red, 36N-P). Pre-test counselling should have involved at least a brief explanation of the legal issues associated with a positive result, and also explanation of coded notification procedures and confidentiality arrangements (judgment Red, 36D-E). Had the question arisen what PD and FH intended to do with the results when they got them, both would have said the other could have access to them (judgment Red, 30T-V). FH at that time did not know he was HIV positive. If FH had told Dr Harvey at the joint consultation that he was not prepared to make his results available to PD, she would not have married him and in all probability would have discontinued any relationship (judgment, Red, 30W-31N).

(iv) The Doctors' duty of confidentiality did not prevent Dr Harvey placing a note on PD's file that there was a joint consultation with FH, and did not mean that the Centre ceased having any responsibility for the welfare of PD in the circumstances (judgment Red, 32K-M). Implicitly, the trial judge found that such cross-referencing ought to have been made: Dr Chen could not rely by way of exculpation on the circumstance that he did not know of the existence of PD. Still less, that he did not know that she was a patient of the surgery who had attended with FH for a joint consultation, because he should have known of the joint consultation and the connection between PD and FH. The practice had the relevant information and it was not open to Dr Chen to argue that he was justified in paying no attention to any duty the practice might owe to PD because he did not know of her existence. From the time PD and FH left the surgery after giving blood they were treated as two separate and unrelated patients, in circumstances where Dr Harvey knew that was not so, and Dr Chen ought to have known it was not so. PD was never spoken to again concerning the outcome of the joint consultation, otherwise than by being told that she could not have access to FH's pathology report.

(v) The Centre had an obligation to PD while she remained its patient to ensure as far as could lawfully be done that she had information concerning her proposed husband's HIV status and the risk to which she was exposed (judgment Red, 42V-X).

(vi) The post-test counselling of FH was inadequate; information of the type imparted to him by Dr Harvey should only have been conveyed in a face to face meeting, and Dr Chen's counselling fell short of that expected (judgment Red, 33L-P). Dr Chen did speak to FH when the latter was given his results, although the consultation fell far short of appropriate; Dr Chen did not know of the joint consultation, nor that the person with whom FH was proposing a new relationship was PD, a patient of the practice. That was possibly because of the unsatisfactory system of recording and cross-referencing information, and also because Dr Chen did not refer the matter to Dr Harvey when FH came in for his results (judgment Red, 31X-32D).

(vii) It was not the duty of the Doctors to tell PD (the patient at risk) that her partner or proposed partner was HIV positive (judgment Red, 33R-34R). Nor was it the duty of the Doctors to convey to her by less direct or obvious means of communication the HIV status of FH (judgment Red 34T-35F). However, this did not have the consequence that there was nothing the Doctors could do to protect PD or at least make her aware of the risks to which she was exposed. While the Doctors were not expected to guarantee that PD would not become infected, and were prohibited from giving her direct information, they were not prohibited from undertaking fairly obvious steps designed ultimately to make her aware of the danger she was in (judgment Red, 42D-F). They could have sought advice from experts in the field, they could have sought advice from the Medical Defence Union, and they could have spoken to the Department of Health. In any case the result would have been advice that FH needed to be counselled to ensure he made PD aware of his condition. That duty was not discharged merely by referring him to RPAHIC (judgment Red, 42G-L).

(viii) It was not good enough to send him to RPAHIC without more (judgment Red, 38Y-39B). The Doctors ought to have asked FH whether he was proposing to tell PD of his condition. Had FH been asked whether he

proposed to tell his future wife of his condition and reminded that sexual intercourse with her without telling her would be an offence, he would have said he would tell her. It would have been difficult for him to have maintained his deception if those he was proposing to deceive were aware of the joint consultation. A doctor was not entitled to assume PD would become aware of FH's condition (judgment Red, 39E-P). The Doctors ought to have contacted RPAHIC to find out whether FH kept the appointment and have raised with RPAHIC the circumstance of the joint consultation and (with PD's consent) that PD was HIV negative (judgment Red, 39S-V). The Doctors had an obligation to ensure that a person in FH's position kept an appointment with RPAHIC, there being a public duty to prevent as far as possible the spread of HIV into the community and to protect so far as they were legally able to do so their own patient (PD). Once they became aware FH had not kept his appointment, the Director-General could have been informed (judgment Red, 40A-E).

(ix) Expert evidence established that by a process of counselling and, as a last resort, coercion, HIV positive patients will tell their partners of their condition (judgment Red, 37M-O).

(x) While the doctors could not reasonably have foreseen that FH might present a forged result to PD, they could have foreseen that he may not have told her his result or might have lied to her (judgment Red, 42M-P). There were at least two occasions when it was open to the Doctors to raise with PD her future intentions concerning her marriage to FH: when she attended for a prescription for the oral contraceptive pill and when she attended for vaccinations. Had this matter been mentioned or reference made to the joint consultation on those occasions she would have told them that both were clear and that she was proposing to get married, at which point the Doctors would have been on notice that FH must have lied to her and probably deceived her. Had anyone raised with PD in late December 1998 or early 1999 the test results which followed the joint consultation she would have told that person that she believed FH was HIV negative, and that would have set alarm bells ringing that Dr Harvey did not begin to hear until May 1999 (judgment Red, 46B-G). While they were not at liberty to tell her of the information they had concerning FH's HIV status, the Doctors could and should have taken other steps to ensure that, as far as was legally possible, PD was aware of the danger she was in. Though

they could not warn PD in terms of her situation, the Director-General and/or his delegate could. Specialists would have advised the Doctors that FH should be referred for counselling in circumstances where he could be persuaded to disclose his condition to PD. They could have told FH that unless he assured them he was proposing to tell PD of his HIV status, they would assume he was placing her in danger and would remind him of their entitlement to refer the matter to the Director-General. Assuming as was likely that FH would have told the doctors he proposed to tell his wife of his condition, without necessarily intending to do so, it would have justified the Doctors in arranging for another joint consultation when the matter could have been further explored (judgment Red, 38J-M).

(xi) Had the process of counselling been properly commenced before the end of 1998, PD would probably have become aware of the HIV status of FH well before August 1999 when she became infected (judgment Red, 40L-R). If PD had even a suspicion about FH's honesty concerning his results, she would not have continued the relationship with him (judgment Red, 38Q-S).

(xii) The duty of a medical practitioner to exercise reasonable care and skill in the provision of professional advice and treatment extended to the provision of information in an appropriate case. While the statutory obligations of confidentiality, and the circumstances in which disclosure may take place for the protection of a person, are relevant, the Doctors were not precluded from taking steps to present reasonably foreseeable harm by "an overriding inconsistent duty". The obligation to preserve confidentiality is overriding only in the sense that details could not be given to PD without the consent of FH, and the statutory obligation operated as a constraint only. It did not preclude the doctors from taking the steps they should have taken but did not take, which resulted in PD becoming HIV positive. It was significant that there was a joint consultation and although the topic of confidentiality was not raised, the duty of the Centre to PD did not end when the Doctors told her that, contrary to her reasonable expectations, she would not have access to FH's results (judgment Red, 40T-41W).

(xiii) FH's presentation of a forged negative result in late November 1998 was not a *novus actus interveniens*, because though actual forgery may not have

been foreseeable, possible deceit or irrational behaviour on his part was (judgment Red, 43H-L). The trial judge observed that "*the medical expert evidence seems to make this clear*" (judgment Red, 43K at [80]).

(xiv) Had the obligation to PD ended when she was given her results by the receptionist and told she could not have those of FH there may then have been an argument that the inadequate pre-test counselling was not causative of the ultimate conduct. However, that obligation did not cease when she was handed her results. Rather it continued while she remained a patient of the practice until at least the end of February. During that period she returned to the practice for further consultations concerning a prescription for the oral contraceptive pill and vaccinations before travel to Ghana. Even if the doctor who saw her on those occasions was unaware of FH's positive result and that FH was the person she was proposing to marry, the Centre had the relevant information and its duty could not be avoided by its inadequate cross-referencing of patient's cards (judgment Red, 44A-I).

(xv) Accordingly, the Defendants were in breach of a duty of care they owed PD and as a result PD became infected with HIV in or about August 1999 (judgment Red, 44K-M).

The appellants' case

63 The appellants' case remains that their statutory obligation of confidentiality to FH under s17 of the Act was such that they could not lawfully have done anything to protect PD. They submit that her only protection was disclosure of FH's HIV positive status and that the only way to have achieved this would have involved breach of that statutory obligation of confidentiality.

64 That statutory obligation is to be found in the mandatory provisions of s17 of the *Public Health Act* 1991 (NSW) and in particular s17(2)(b), which is in the following terms:

> "**17. Protection of identity**
>
> (1) A medical practitioner must not state the name or address of a patient:
>
> (a) in a certificate sent to the Director-General under section 14 in relation to a Category 5 medical condition, or
>
> (b) except as may be prescribed, in a written or oral communication made by the medical practitioner for the purpose of arranging a test to find out whether the patient suffers from a Category 5 medical condition.

> (2) A person who, in the course of providing a service, acquires information that another person:
> (a) has been, or is required to be, or is to be, tested for a Category 5 medical condition, or
> (b) is, or has been, infected with a Category 5 medical condition,
>
> must take all reasonable steps to prevent disclosure of the information to another person.
>
> (3) Information about a person that is of a kind referred to in subsection (2) may be disclosed:
> (a) with the consent of the other person, or
> (b) in connection with the administration of this Act or another Act, or
> (c) by order of a court or a person authorised by law to examine witnesses, or
> (d) to a person who is involved in the provision of care to, or treatment or counselling of, the other person if the information is required in connection with providing such care, treatment or counselling, or
> (e) in such circumstances as may be prescribed.
>
> (4) A medical practitioner or other person who fails to comply with the requirements of this section is guilty of an offence.
>
> Maximum penalty: 50 penalty units.

65 A "*category 5 medical condition" includes "Acquired Immune Deficiency Syndrome" and "Human Immunodeficiency Virus infection*".

66 By s75 of the Act, mirroring s17(3), it is an offence to disclose information without lawful excuse. "Lawful excuse" includes disclosure with the consent of the person to whom the information relates, and prescribed circumstances.

67 The regulations prescribe that disclosure may be made to the Director-General where a healthcare worker has reasonable grounds to believe that a failure to disclose could place the health of the public at risk, in order that the Director-General or his delegate can perform the necessary tracing and take the necessary actions to protect public health. Regulation 10 provides that the Director-General may notify a person whom he or she believes may have been in contact with a person suffering from HIV, of measures to be taken and activities to be avoided in order to minimise the danger of contracting or passing on the condition. Regulation 16 requires a pathology laboratory to notify the Director-General of the confirmed HIV antibody positive result. The notification must not disclose the name or address of the patient. It was in compliance with this obligation that the laboratory passed FH's results to the Director-General in November 1998.

68 Finally, the Act provides for offences. An offence is committed by a person who knows that he or she suffers from a sexually transmissible medical condition and has sexual intercourse with another person without informing the other person of the risk of contracting that condition and the person concerned has "*voluntarily agreed to accept the risk*"; s13(1) of the Act.

69 Central to the appellants' case is s17(2)(b) of the Act. Clearly enough s17(2) was capable of application to and did apply to the appellants. Thus Dr Harvey was "*a person who in the course of providing a service*" namely, procuring the blood test, acquired "*information that another person*" (FH) has been tested for a category 5 medical condition (s17(2)(a)) and that FH "*is, or has been, infected with a category 5 medical condition*" (s17(2)(b).

70 I consider that it is clear that the concluding "*another person*" in s17(2) (to whom disclosure is to be prevented) must mean to another person other than the person (FH) about whom the information had been obtained. In the present context this would certainly include PD unless FH consented to disclosure to her (s17(3)(a)).

71 I agree that the obligation to "*take all reasonable steps to prevent disclosure of the information to another person*", goes further than a simple prohibition on disclosure. It imposes an obligation positively to take steps against disclosure, though no more than the steps which were reasonable.

72 An exception to that prohibition here relevant, is that contained in s17(3)(a). It permits disclosure where it is "*with the consent of the other person*" meaning in the present case that of FH.

73 The prohibition is one that gives rise to a criminal offence, as s17(4) makes clear.

74 The appellant's case is fundamentally that liability in negligence on the doctors' part does not comport with the legislative policy exhibited by those statutory requirements. It was submitted by Mr Brereton SC for the appellants in opening that:

> "in this State, for public health reasons Parliament has made a policy decision that the responsibility for the decision of someone who suffers from HIV positive status or the acquired immune deficiency syndrome is to notify anyone else of that condition and to take steps to protect the spread of the disease is the responsibility of that person and no one else. The only exception to that is in cases where there is a significant threat to public, as distinct from private, health wherein exceptions prevail. Fundamentally the policy decision has been made in this type of case that uniquely the responsibility is that of the patient alone." [Appeal transcript 1.20-35]

75 The appellants' capacity to foresee damage for breach of that duty, though an important element, is not sufficient to establish liability if there be a countervailing duty which either denies or cuts down the duty of care upon which the liability is based. The appellants submit that that countervailing duty is here found in the legislation.

76 The appellants contend that in accordance with the well-known passage in the joint judgment of the High Court in *Sullivan v Moody* (2001) 207 CLR 562 at 581 [55], the duty necessary to ground liability in the present case was incompatible with the responsibility imposed by s17(2)(b) to prevent disclosure.

77 That passage is as follows:

> "[55] More fundamentally, however, these cases present a question about coherence of the law. Considering whether the persons who reported their suspicions about each appellant owed that appellant a duty of care must begin from the recognition that those who made the report had other responsibilities. A duty of the kind alleged should not be found if that duty would not be compatible with other duties which the respondents owed."

78 Further in the joint judgment (at [60]) the possibility of multiple duties is recognised as not of itself ruling out the possibility that a duty of care is capable of being owed to a plaintiff; "*people may be subject to a number of duties, at least provided they are not irreconcilable .....*" However, "*if a suggested duty of care would give rise to inconsistent obligations, that would ordinarily be reason for denying that the duty exists .....*".

79 The trial judge concluded that "*the practice had an obligation to PD while she remained its patient to ensure, **as far as could be lawfully done**, that she had information concerning her proposed husband's HIV status and the risk to which she was exposed*". [emphasis added]

80 The appellants' case in its essentials comes to this. That compliance with the statutory obligation to take all reasonable steps to prevent disclosure meant that it could not be lawfully done for the appellants to disclose to PD the result of FH's test, whether directly or by any indirect means. This is said to include means which merely facilitate the information coming to PD. Accordingly, fulfilment by the appellants of their duty to PD, when the content of that duty is thus properly understood, could not have avoided the tragic results for PD following her husband's cruel deception. It was submitted insofar as there were shortcomings in counselling PD or FH, pre or post testing, these were generally not in truth shortcomings when the statutory obligation is taken into account but in any event not such as to have been legally causative of PD's injury.

81 It was accepted by the appellants, for the purposes of this appeal, that in the context of a joint consultation such as occurred here, "*Dr Harvey owed both his patients – PD and FH – a duty to address, in the course of consultation, the question of mutual disclosure of results, and the possibility of discordant results. He did not do so. In that respect breach of duty was established*" (Orange, 28 at para 27).

82 But the appellants contend that this breach of duty was not legally causative of the respondent's loss. This was because the Centre receptionist declined, correctly it is said, to make FH's results available to PD, so the ultimate damage she suffered could not be attributed to that breach of duty. I quote below the appellants' articulation of that argument (Orange, 28):

> "28. However, ultimately, the Centre receptionist told PD that she was not entitled to a copy of FH's pathology report. That advice was correct. By saying that she was not entitled to his results, it was made clear enough that she was not entitled to rely on the Doctors for that information any longer, if she ever had (and the better view is that she relied on FH, not the Doctors, to provide his test results to her). Thus, accepting that there was a breach of duty in respect of the content of the initial joint consultation, nonetheless - as His Honour seems to have found - the eventual damage cannot be attributed to that breach, because in the interim the Centre informed PD that she was not entitled to FH's results, and she ultimately sought and obtained for herself, directly from him, what he represented to be those results.
>
> 29. Accordingly, His Honour, while finding breach of a relevant duty owed to PD in respect of pre-test consultation and counselling, did not find that that breach was causative of damage, and would have erred had he done so. Any shortcomings in pre-test consultation and counselling accordingly cannot form the basis of liability of the Doctors to PD."

Disposition of the Appeal

83 I consider that the trial judge was correct in concluding that Dr Harvey owed both his patients PD and FH a duty to address, in the course of that initial joint consultation, the need for consent to disclosure, the manner of disclosure, and the possibility of discordant results. That duty sprang from the obligation the law imposes on a medical practitioner to exercise reasonable care and skill not only in treatment, but also in the provision of professional advice; *Rogers v Whitaker* (1992) 175 CLR 479 at 483. While the existence of that duty was not challenged, the manner of its performance was said to be constrained by the Act.

84 There is however no challenge to the finding that "*the plaintiff believed, and as I find, on reasonable grounds, that she would have FH's results and he would have hers*.", though the topic was not raised in the joint consultation; Judgment Red, 19X at [10].

85 At [47], the trial judge concluded, "*PD was plainly of the opinion that she was entitled to FH's results. He had consented to her having them before the joint consultation*."; Red, 30.

86 The trial judge also found that while

> "FH did not give his consent to Drs Harvey and Chen to disclose his result to PD, this was because the question had not arisen at the conference by reason of Dr Harvey's negligent failure to inform them of the need for their consents to disclose their results to each other and his negligent failure to raise how they propose to deal with discordant results should that occur"; Red, 30 at [47].

87 The critical finding is then made at [48] that "I am of the opinion that had the question arisen concerning what the parties intended to do with the results when they got them, both would have said the other could have access to them". Moreover, the trial judge accepted PD's evidence that, "if FH were not prepared to have results made available to her she would have discontinued her relationship with him". As to reliance by PD on her doctor, the trial judge records that "it is common ground that PD should not have received her results from the receptionist but should have received them from a medical practitioner and to have been told, in effect, that the results were not necessarily definitive because of what has been described as the 'window' period of three months prior to the test being undertaken within which HIV could have been contracted but without a positive result appearing in the test"; at [14] Red, 20.

88 Those findings need to be coupled with the fact that PD and FH arranged the tests through Dr Harvey by requiring a joint consultation. This was for the clearly stated purpose of ascertaining whether either had any sexually transmitted diseases, before engaging in unprotected sex in contemplation of a new relationship. Those findings and that evidence underpin the conclusion I reach. It is that, had Dr Harvey done what he was in duty bound to do, namely, raised the question of consent to disclosure, mutual disclosure of results, and the possibility of discordant results, the parties would more likely than not have consented to their results being made available to each other by Dr Harvey at a further joint consultation. I also infer that if FH had refused, then their relationship would have terminated. Had either occurred, I conclude that PD would not have been vulnerable to FH doing what he did, namely hiding his results and substituting forged ones with the tragic result that followed. I elaborate on my reasons below, starting with the statutory impact of s17(2)(b) of the Act.

89 In my view, s17(2)(b) of the Act does not preclude a proper process of pre-test counselling encompassing the need for consent, how to receive the test results and dealing with the possibility of discordant results. Care would be needed on the latter, to avoid on the one hand being unduly alarmist while on the other remaining properly candid about the possibilities. The taking of all reasonable steps to prevent disclosure does not extend to require the further unreasonable step of holding back from counselling on those three matters. PD would certainly have wanted to receive the test results for her partner and herself in the most reliable way. Dr Harvey should have been conscious of the possibility of discordant results given PD's expressed concern that FH came from Ghana. This is especially as Dr Harvey accepted there was a greater risk of sexually transmitted diseases from that area (even if he did not concede that his understanding accorded with PD's belief that there was a higher risk that a person from Ghana would be HIV positive than one from Australia). The trial judge moreover had evidence before him that led him to conclude that it was a fact "*that in circumstances where persons may be expected to go into denial, become angry etc responsible behaviour cannot be assumed and certainly not simply because the patient is well dressed and understands English.*" To require the doctor to hold back from raising such a matter because it might encourage a patient's consent in advance to a process of mutual disclosure via the medical practitioner would be to require a step that, in the statutory context, was unreasonable; that is to say, unreasonable in circumstances of an initial joint medical consultation for a couple contemplating marriage who seek that both be tested for sexually transmitted diseases preparatory to engaging in unprotected sex.

90 I conclude that s17(2)(b) of the Act would not mandate or justify holding back these matters from pre-test counselling in the present circumstances. First, I consider that for a doctor in those circumstances to seek to bring about a situation where it is more likely that both parties' consent would be forthcoming to mutual disclosure at a further joint medical consultation does not involve any failure to take all reasonable steps to prevent disclosure. Moreover, at that time there would be as yet no test results able to be disclosed. There is nothing unreasonable in taking a lead from the couple's own expressed needs in their joint consultation and seek to facilitate a situation of mutual disclosure in the presence of their doctor. Indeed it would call for **unreasonable** steps on the part of the doctor to deny in those circumstances that important element of counselling.

91 What of the fact that at the time of first counselling, the test results are not known; does that vitiate consent to their mutual disclosure at a further joint conference? It has been said that "*you cannot consent to a thing unless you have knowledge of it* (per Jessell MR *M R Ex parte Ford; re Caughey* (1876) 1 Ch D 521 at 528). Neither member of the couple can be assumed to know in advance his or her future test result or that of the other. In that sense their knowledge is incomplete. But, analogous to knowing the risks of an operation but not its outcome before the operation is carried out, each of PD and FH must have known that there was a risk of the result testing positive. As the majority judgment in *Rogers v Whittaker* ((supra) at 490) pointed out, the phrase "informed consent" is amorphous and apt to mislead, depending as it does on contrasting context; for example the consent necessary to negative trespass as against negligence. It would be absurd to construe this legislation, with its evident protective purpose, as precluding the kind of pre-test counselling that should have occurred on the basis that this was to obtain an uninformed consent in advance to such disclosure of test results. Had a further joint consultation occurred by arrangement at which the test results were mutually disclosed through their doctor's facilitation, I consider that there is nothing in this process precluding the necessary prior consent in terms of s17(3)(a) of the Act. That consent I consider would have been forthcoming by the time of such further joint consultation had such joint consultation occurred for the purpose of mutual disclosure of the test results.

92 Indeed if reliance had to be placed solely on post-test counselling (because no consent given in advance could be an informed one), there would be a much greater constraint on counselling. That is by reason of the concern about breaching s17(2)(b) when the test results were known. Then the doctor may well feel constrained by knowing the actual test result from giving any hint of it in breach of s17(2(b). The doctor would equally be unwilling to risk vitiating any consent under s17(3)(a), by reason of it being said to result from a breach of s17(2)(b). However, in view of the conclusion I have reached on the pre-test counselling, and the variety of circumstances that can here arise, I express no conclusion on whether that concern would be well-founded in law.

Causation

93 On causation, I do need to consider whether, if Dr Harvey had provided adequate pre-test counselling of joint disclosure taking into account the possibility of discordant results, FH

(a) would have declined to have his results or their joint results made available at a joint consultation, and

(b) instead insist that they make their results available to each other privately and if so,

(c) whether that would have led to the termination by PD of their relationship.

94 One must hypothesise this occurring in circumstances where Dr Harvey was not in breach of his duty to address in the course of consultation the question of mutual disclosure of results and assume, contrary to what occurred, that he actually raised the matter. It must also be on the hypothesis that Dr Harvey himself (or Dr Chen) would not have breached his duty in having the results made available other than through himself (or Dr Chen) and in particular would not have had the results wrongly made available through the receptionist.

95 The trial judge's findings include the important finding at [49], expressed in the passive voice, that "*if FH were not prepared to have his results* ***made available to her*** *she [PD] would have discontinued her relationship with him*". One could envisage PD's suspicion from such an insistence by FH that he would not agree to the medical results being given through their jointly consulted doctor but only through him.

96 Indeed the very purpose of the joint consultation was not merely to carry out the relevant tests. That could have been done by a simple referral to a pathologist. Rather it was to obtain advice from their doctor as to sexually transmitted diseases and in particular as to the HIV virus. At a joint consultation with their doctor their results can be shared without risk of concealment and so that their implications, if discordant, can, as they would expect, be properly explained by their doctor. They had clearly signalled, by coming as a couple, that they were seeking joint and not separate advice. I have earlier concluded that the inference properly to be drawn is that had Dr Harvey raised the matter of disclosure and the possibility of discordant results they would either have agreed to joint disclosure or, if FH refused, PD would have discontinued her relationship with him.

97 The expert evidence of Dr Carmella Law supports this. She stated that "*an HIV test should never be performed without pre-test counselling*" (Blue, 8T). While she refers to the possibility of providing one or both parties with the opportunity in a joint consultation for their sexual history to be separately recorded, that in no way detracted from her conclusion that "*the joint session would also provide an opportunity to check the couple's preferences on how they are going to obtain their results i.e. jointly or separately*" and "*how they would manage the situation if one or both of them were to turn out to be positive*"; Blue, 9R-T.

98 Moreover the subject matter of the conference should have included "*making sure the client has an appointment to return to pick up the results in person*"; Blue, 9E.

99 She refers to the need to "*discuss briefly who to tell and how to tell contacts*" again as part of the joint conference. This was to be covered in greater detail if, as here,

the individual is assessed to be at higher risk of testing positive so one "*geared the pre-test counselling more towards a likely positive result*"; Blue, 9I-L.

100 Dr Law in cross-examination gave these answers:

> "Q. So you cannot assume can you that simply because a couple comes in together, they will authorise the doctor to reveal their result to the other partner, can you?
>
> A. Not usually.
>
> Q. No?
>
> A. But we always check, and in my experience, I don't assume when they come in together that they will have the tests shown to each other, and I say that very clearly, what I do is, I ask them specifically and I document in my notes, 'Are you happy to be in the presence of each other when you get the test results?' and most of the time when they attend together for a test they want the test together, that's the whole idea of about doing this together." T, 118.6-.21.

101 The significance of Dr Harvey's failure to explain the need for consent to access the test results and the understandable misconception on PD's part from that failure is brought out in the following passage of cross-examination of PD:

> "Q. When you went back to get your tests, what was your understanding as to whether you could have access to your future husband's records or not? Did you have an understanding about that? What did you think?
>
> A. From my understanding, I thought I could just get them because we went together. I didn't know ….
>
> Q. That's why you asked for them, I suppose?
>
> A. Yes, but I didn't know the legal, you know, the legal – I'm not a lawyer, but from my understanding I thought I could get them."; T, 137.20-.30.

102 Those answers were given to the trial judge but when counsel for the doctors resumed his cross-examination, the following question and answer indicated the inadequacy of the receptionist's response:

> "Q. But you were left in no doubt when you went back for your records that you could not have access to his records; correct?
>
> A. I was told that they were confidential." T, 137.32-.35.

103 This passage indicates that instead of the receptionist pointing out that whilst the results were confidential they could be made available with the consent of her partner, PD was simply given the misleading and incomplete information that she could not have access to his records because they were confidential. Had Dr Harvey raised the matter at the initial joint conference, I am satisfied on the findings and evidence that the most likely result is that he would have elicited the response that each consented to the other's results being made available at a further joint conference with Dr Harvey (or another doctor if he were unavailable). Having chosen to get joint medical advice rather than go to a pathologist direct, PD at least would hardly, **if given the choice**, have opted to receive the results from an unqualified receptionist with no knowledge of the circumstances of their original joint consultation. Had the results been conveyed to them together at a joint consultation, I consider that PD's damage would not have occurred. That would satisfy any common sense notion of causation as well as the "but for" test; *March v Stramare Pty Ltd* (1991) 171 CLR 506 at 516, 522, 525 and 530.

104 I agree also with the respondent's submission that the appellants cannot rely upon their subsequent breach of duty in permitting the receptionist to consult with PD for the purpose of providing her results. This is in seeking to be relieved of liability for the damage which was caused by Dr Harvey's antecedent breach of duty in failing to discuss with his patients the issue of the provision of results and then failing to have those results made available either through himself or another properly qualified medical practitioner properly informed of the earlier consultation.

105 The trial judge dealt with causation briefly. But in the course of doing so he made this observation:

> "Had the obligation to PD with respect to the blood tests ended when she was given her results by the receptionist and told she could not have those of FH there may have been an argument to the effect that although there had been inadequate pre-test counselling the damage she suffered was relevantly 'caused by' the conduct of FH. But, in my opinion, the obligation to the plaintiff did not cease when she was handed her results by the receptionist and told she could not have those of FH. The obligation to look after her interests insofar as that could be lawfully done continued while she was a patient of the practice i.e. until at least the end of February 1999." Red, 43-4 at [82].

106 Beyond raising it as a possible argument, the trial judge did not accept the argument that the damage was relevantly "caused by" FH. I prefer the reasons I have earlier stated for that conclusion, based on the appellants' failure in **pre-test** counselling and its consequences in rendering PD in trusting FH vulnerable to FH's deceit. Vulnerability is an important factor if not a prerequisite for the protection afforded by the law of negligence, as is made clear by a long line of High Court decisions, such as *Crimmins v Stevedoring Industry Finance Committee* (1999) 200 CLR 1 at 24-6, 39-41, 43 per McHugh J and 85 per Kirby J. In particular I consider that the appellants ought not escape the consequences of their negligence by reason of FH's deceit, when it was itself not unforeseeable. I do so, applying the second limit of the test of causation adopted in *Ruddock v Taylor* [2003] NSWCA 262 at [87]. The normative question to be asked is

ought the defendant be held liable for the harm sustained, to which the answer remains yes.

107 It is therefore not necessary, in order for the respondent to succeed, to rely on any failure in post-test counselling. Concededly, the post-test counselling was clearly inadequate. First, each doctor failed to urge upon FH the importance of disclosing his adverse test result to his sexual partners (Red, 33N-P; 38T-39Q). Second, neither doctor ever raised with FH whether he intended informing PD of his condition (Red, 38T). Had Dr Harvey carried out all of the post-test counselling, he would have been fully aware of PD's and FH's relationship from the earlier joint consultation. Had he properly recorded upon the treatment record card the fact of a joint consultation and that PD was about to enter a new relationship (he did neither) and had there been a system for that record in turn being automatically available to Dr Chen, he would have been aware of the circumstances concerning FH and PD's intention to marry and the purpose of the original tests. His counselling could then have taken that critical circumstance into account. It did not.

108 Making such note of the joint consultation and its purpose could in no way infringe s17(2)(b) of the Act. Nor, consistent with the trial judge's findings (Red, 32K-M) do I consider it would have infringed any duty of confidentiality to PD or FH. There remains the question whether a multi-doctor medical centre should be excused by that circumstance from the obligation not only to make adequate records but also to ensure their availability by a cross-referencing system to whoever is the treating doctor at the time. Lack of such cross-referencing leaves patients of such a practice at risk that critical information in their files, affecting the safety of on-going treatment, would be unavailable, so creating a serious and from the patient's viewpoint unanticipated hazard. However, as I do not need to reach any concluded view regarding post-test counselling, I consider this related question is best left to be determined in a case requiring its determination.

Conclusion

109 Had Dr Harvey fulfilled his duty to address in the course of the initial joint consultation the question of mutual disclosure of results and the possibility of discordant results the probable result is that Dr Harvey would have secured the consent of FH as well as PD to receiving those results together from Dr Harvey and each would have consented to their respective results being known to the other through Dr Harvey at a further joint consultation. But in the contingency that FH refused, the finding remains that PD would have terminated her relationship with FH. In either case, PD would have escaped the injury she suffered because FH would not have been in a position to deceive her. It is unnecessary for me to consider the matters raised in the respondent's Notice of Contention.

Post-result counselling

110 The appellants deny that they owed any relevant continuing duty to PD, arising from her continuing status as a patient of the Centre, and as a person the doctors ought to have known was at risk from FH's known HIV status. It is however unnecessary to consider that question in light of the conclusion earlier reached. In particular I do not need to reach any final conclusion as to whether the statutory duty imposed by s17(2)(b) would have precluded the doctors giving post-test counselling urging FH to disclose to

PD his positive result or the likely result if they had. Nor do I need to consider the causal effect of the other inadequacies and omissions in post-test counselling and follow-up in relation to FH, or the likely result if the Director General had been notified. This latter is on the supposition that the doctor concerned worked out from proper cross-referenced medical records that PD and FH were engaging in unprotected sex following her attending for vaccinations to go to Ghana and for a prescription for the contraceptive pill. The appellants contend that to urge or even counsel FH to disclose his HIV status to PD is inconsistent with the statutory obligation imposed by s17(2)(b) and that in any event it was not reasonable for her to rely on the doctors to procure such disclosure. The appellants contend that the content of the duty is limited to warning the infected patient of the need to take appropriate precautions. Further, that this duty was sufficiently fulfilled by

(a) Dr Harvey in advising FH not to have unprotected sex, though he did not raise any issue arising out of the joint consultation or ask whether he proposed to tell PD the result (Red, 51 at [18]); and

(b) Dr Chen in telling FH when he attended to collect his results that illness was sexually transmissible and could be transferred to others (Black, T, 191.11-194.17);

citing Bell J in *BT v Oei* [1999] NSWSC 1082 at [60-98].

111 It is unnecessary to consider these issues in light of my earlier conclusion that proper pre-test counselling would have resulted in a joint consultation to obtain the test results from a doctor (or if declined termination of the relationship), and that such disclosure so brought about would not have involved any breach of s17(2)(b) of the Act or precluded the application of s17(3)(a). Questions concerning the scope for post-result counselling and the boundary line between on the one hand taking reasonable steps to avoid disclosure and on the other providing proper advice designed to maximise the prospect of lawfully obtained consent to disclosure to a vulnerable partner, is best left to cases that require the resolution of those difficult issues.

Cross-appeal – Recovery of additional costs of child care for PD's second child conceived after PD became aware of her having become HIV positive from a second party.

112 The essential facts relevant to this issue are not in dispute and are set out below:

(i) PD had a seroconversion illness in September 1999 (Red, 24U-W);

(ii) PD found out she was HIV-positive in January 2000 (Red, 24W-Z, 27D-F);

(iii) PD's first child - who was the child of FH, and was conceived before she knew she was HIV-positive and probably before she was HIV-positive - was born in February 2000 (Red, 24F);

(iv) PD and FH were divorced in May 2001 (Red, 44T);

(v) Sometime after the divorce in 2001 PD commenced a relationship with a man from Sweden, to whom she became engaged, who was also HIV-positive (Red, 44V-W);

(vi) PD, prior to such engagement, in March 2002, gave a history to Dr Sippe psychiatrist in March 2002 that she was in a relationship with an HIV positive man from Sweden; that she expected he would return to Sweden and that he "*was not ready for commitment*" (Blue, 86I-M). However, they did become engaged. The trial judge concluded that as an HIV positive man, the father would be unlikely to be given permission to reside permanently in Australia (Red, 52);

(vii) PD's treating immunologist Dr Garsie reported in January 2002 that PD was aware that she risked passing on HIV to any future offspring or sexual partner; that she "*displayed a high level capacity to understand and see the implications of the information for her*" (Blue, 60G-K);

(viii) PD's second child was born of that relationship, on 29 November 2002 (Red, 44X);

(ix) That second child was conceived voluntarily by PD in circumstances in which she knew she was HIV-positive;

(x) On the probabilities PD will become afflicted with an AIDS-defining illness in about 2014, and die in about 2016 (Red, 48P-R);

(xi) PD will be able to care for her children until 2014, but not thereafter (Red, 54B-D);

(xii) For the period from 2014, PD was held entitled to damages for loss of future earnings on the footing that she would otherwise have been in fulltime employment (Red, 45O-46J, 51R-52H). Similarly, she received damages for lost earnings during the "lost years" on the same basis (Red, 52N-R).

113 There was no evidence before the trial judge that there is an increase in risk of offspring contracting HIV if **both** partners are HIV positive, that is, as distinct from just the mother.

Additional costs of child care

114 The Appellants submit that the trial judge correctly declined to award damages under this head, because the cost of future child care for the second child will be the result of the voluntary, informed and unreasonable (in the context of visiting the consequences on the appellants) decision of the respondent. This, importantly, is a category of consequential **economic** loss, though stemming from the injury PD ultimately suffered of HIV-Aids.

115 The appellants further submit:

(i) while, where the compensable injury has reduced a plaintiff's ability to determine whether or not it is appropriate or responsible or reasonable for her to have children, the cost of caring for them may be recoverable; *Sullivan v Gordon* at [67]. That is not so where the plaintiff retains the ability to make that judgment. PD retained that ability, and exercised it. It could not be said that her conduct in having the second child was caused by the appellants' negligence; rather, it was caused by her own informed and deliberate decision. It is not reasonable to impose upon a defendant the cost of care of a child **voluntarily** born by the plaintiff after an injury; *Sullivan v Gordon* at [14]; *Beck v State of New South Wales* [2001] NSWSC 278.

(ii) To allow recovery in this context would be to compensate a plaintiff for the consequences of conduct which is calculated, not to mitigate, but to aggravate, her damages; and to put a defendant at the mercy of a plaintiff's decision to have more children. The implications - given the cost of attendant care, for up to 18 years - are potentially enormous.

(iii) Moreover, any such claim duplicates and overlaps the claim for lost future earnings (including the lost years), which were assessed on the basis of PD being in fulltime employment. Had PD exercised her earning capacity - for the loss of which she is to be compensated - then she would have required child care assistance, at least during the day, in any event.

(iv) Further, the claim ignores the role which the father of the child would play in providing for the care of the children.

116 At the outset one may accept two propositions as not really debatable. First, it was reasonably foreseeable that PD, even knowing of her condition, would decide to have a second child. If one views matters at the time of the original consultation, PD was 24 and had at that time no children. There was nothing to indicate that she intended to hold back from having children at some future date. By the time the second child was born it is true that some four years had elapsed but PD was still under 30. She had already successfully

given birth to her first child after undergoing anti-retroviral drug therapy. This, together with having a caesarean delivery, resulted in that child being born HIV free; Red, 45 at [88]. She was able to follow the same course with her second child. There is no evidence to indicate that a father who is HIV positive adds to the risk of a child being born HIV positive from a mother with that condition.

117 So to conclude merely removes an impediment to recovery but is not sufficient of itself to enable PD to succeed.

118 Similarly with the second proposition. As the trial judge recognised, there could be no obstacle to her recovery merely by reason of the special damage being not for the cost of looking after herself but for loss of capacity to care for her second child for the six years till the child turns 18. Such an allowance is properly based on the principles underlying *Griffiths v Kerkemeyer* (1977) 139 CLR 161.

119 *Sullivan v Gordon* thus allowed special damages for the value of the lost capacity to care for the two children born after the accident. As Ipp JA observes, in the draft judgment that I have had the advantage of reading, that was a claim for loss of **capacity** to care for others and not a financial loss claim as such. This allowance moreover was in *Sullivan v Gordon* in circumstances where it was the accident itself which rendered the plaintiff incapable. The brain damage she suffered made her not only incapable of caring for her two children born after the accident but incapable of deciding responsibly whether or not she wished to have children at all in such circumstances. Here however there is no such direct connection between the defendant's negligence and the birth of a child.

120 The permissibility of recovery for the present claim can be considered in various ways. These the appellants identify. First, whether damage flowed from the original act of negligence such that it should be recoverable. That is a question of causation involving normative issues. But it can be equally framed as a scope of duty question.

121 In that context, the question can be posed, did the scope of the doctors' duty of care comprehend the kind of consequential loss for which claim is made here. Though recovery sought is not for pure economic loss arising out of a relationship, nonetheless as Gleeson CJ expressed it in *Cattanach v Melchior* (2003) 77 ALJR 1312 at [30], liability "*has to be justified by showing that there was a duty of care to protect the claimants from that kind of harm*".

122 Third, in damage mitigation terms, the issue becomes whether the respondent has been shown to have acted unreasonably in failing to mitigate her damage but rather aggravate it.

123 Professor Jane Stapleton explains in her article "Cause-in-Fact and the Scope of Liability for Consequences" (2003) 119 LQR 388 that even after one has determined that the negligent conduct in question played a part in bringing about the harm in an historical sense, there is a second aspect concerning "*the 'appropriate' scope of liability for the consequences of tortious conduct*" (at 411).

124 Considered as a question of causation the starting point is still the application of common sense (*March v E & M H Stramare Pty Limited* (supra). This is also the test for whether some particular damage resulted from the negligent act or (as here) omission (*Medlin v State Government Insurance Commission* (1995) 182 CLR 1). The appellants as PD's doctors in common sense terms and certainly as a matter of historical involvement, played a significant role in the respondent being faced with the choice of limiting herself to one child or placing herself in likely need of child care once incapacitated. Though it be the case that she chose the latter course, that choice was in a sense forced on her, if she were to have a further child at all. That however still leaves a second question, similar to the scope of duty analysis. That question is whether the doctors "***ought*** *to be held liable to pay damages for that harm*". That is the second stage of the two stage enquiry, described by Ipp JA as one which "*may involve normative issues of a general kind … and whether the damage claimed is too remote.*"; *Ruddock & Ors v Taylor* (supra) at [87]. Most recently Hayne J in *Pledge v Roads & Traffic Authority* [2004] HCA 13 speaking in the preferable terms of "legal responsibility" (at [10]) adopted just such a two stage enquiry:

> "The questions that are relevant to legal responsibility are first, whether, as a matter of history, the particular acts or omissions under consideration (here the acts or omissions which led to the presence of the foliage, and the parking bays, and the absence of warning signs) did have a role in the happening of the accident. It is necessary then to examine the role that is identified by reference to the purpose of the inquiry – the attribution of legal responsibility …. It is at this second level of inquiry that it may be necessary to ask whether, for some policy reason, the person responsible for that circumstance should nevertheless be held not liable [Stapleton, "Unpacking 'Causation'", in Cane and Gardner (eds), Relating to Responsibility, (2001) 145 at 166–173]."

125 The joint judgment in *Sullivan v Moody* at 415 [49] warns that in determining cases of negligence and causation by reference to what is just and reasonable or fair, principle must have primacy, but that there are also policies at work which can be identified:

> "[t]he question as to what is fair, and just and reasonable, is capable of being misunderstood as an invitation to formulate policy rather than to search for principles. The concept of policy, in this context, is often ill-defined. There are policies at work in the law which can be identified and applied to novel problems, but the law of tort develops by reference to principles which must be capable of general application, not discretionary decision making in individual cases."

126 But importantly the High Court did not exclude altogether consideration of what is fair or unfair, for in the next passage (416 at [53]) there is an acknowledgment that:

> "[D]evelopments in the law of negligence over the last 30 or more years reveal the difficulty of identifying unifying principles that

> would allow ready solution of novel problems. Nonetheless, that does not mean that novel cases are to be decided by reference **only** to some intuitive sense of what is "fair" or "unfair". There are cases, and this is one, where to find a duty of care would so cut across other legal principles as to impair their proper application and thus lead to the conclusion that there is no duty of care of the kind asserted." [emphasis added]

127 Here there is no guiding principle which, without recourse as well to legal policy, suffices to answer the scope of duty question. In determining what is here the proper scope of the doctors' duty of care (or the proper scope of their liability for the consequences of its breach) one must begin with the voluntary decision by PD to have a second child, knowing that she was HIV positive. This was when she was in no way incapacitated from making that decision by reason of the earlier negligence of the doctors, in contrast to the position in *Sullivan v Gordon*. The appellants contend that decision, and the consequences which followed, because it was the product of voluntary and informed conduct, in causation terms must amount to an interruption or termination of the causal force of the original negligence. That conduct, say the appellants, constituted a *novus actus interveniens*, involving independent and unreasonable action on the part of the respondent seeking to recover. That in scope of duty terms, broke the chain of legal responsibility eclipsing any role the doctors' negligence may have played. As I explain, I consider that approach unduly simplistic in its assumption of unreasonableness on the part of PD.

128 Similar issues arose in the well-known case of *McKew v Holland & Hannen & Cubitts (Scotland) Ltd* [1969] 3 All ER 1621. There the defendant, although responsible for initially injuring the plaintiff's leg, was held nevertheless not liable when the plaintiff subsequently fractured an ankle in trying, alone and without even the assistance of a handrail, to descend a steep staircase. Lord Reid at 1623 put the matter in these terms:

> "But if the injured man acts unreasonably he cannot hold the defendant liable for injury caused by his own unreasonable conduct. His unreasonable conduct is *novus actus interveniens*. The chain of causation has been broken and what follows must be regarded as caused by his own conduct and not by the defender's fault or the disability caused by it … a defender is not liable for a consequence of a kind which is not foreseeable. But it does not follow that he is liable for every consequence which a reasonable man could foresee."

129 Reasonableness in the present case starts with the question whether it was reasonable for PD to have a second child in the circumstances. But that is not the end of the matter. The second question which must be answered is whether, accepting it may have been reasonable for PD to do so, is it reasonable to hold the appellant doctors liable? Was it nonetheless within the proper scope of the doctors' duty of care (or liability for consequences of its breach) for the doctors to be liable to compensate PD for the resultant child care once PD becomes incapacitated to provide it herself. The trial judge simply treats his affirmative answer to the first question as determinative. He concludes that

"*conceiving and raising children is a natural incident of the human condition*"; Red, 51 at [114].

130 Beazley JA went further in *Sullivan v Gordon* (at 335): "*In any event, it is probably the case that there is a common law right to procreate*" citing *Re "Jane"* (1988) 94 FLR 1 and Article 23(a) of the International Covenant on Civil and Political Rights. But as Ipp JA points out in his draft judgment in 1992, the High Court left open the question whether "*there exists in the common law a fundamental right to reproduce which is independent of the right to personal inviolability*". *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218. More recently Gleeson CJ in *Cattanach v Melchior* (supra), though in the minority, was not contradicted by the majority in observing that "*parents have **the freedom** to chose, and therefore to limit, the size of their family*" (at [23]) [emphasis added]. We are here concerned with the converse of a parental decision to limit the size of a family. It may be expressed as exercising the freedom to choose to have a further child. For the purposes of what follows, I shall assume that such a freedom exists; it is not necessary to go further and characterise it as a right. Here, while the parents face obvious difficulties, it is clearly not a situation that warrants the conclusion that the decision was inherently irresponsible. The trial judge's finding, not challenged, leaves no room for suggesting that PD could not herself care for the child in its early years, until around the age of 12. Nor was there any submission made that the child, given the precautions taken prior to and at the birth, was at high risk of becoming HIV positive in the circumstances.

131 In *March v Stramare* Mason J considered (at 517) that the decision in *McKew* (supra) could be explained as:

> "…a value judgment that it would be unjust to hold the defendant legally responsible for an injury which, though it could be traced back to the defendant's wrongful conduct, was the immediate result of unreasonable action on the part of the plaintiff. But in truth the decision proceeded from a conclusion that the plaintiff's injury was the consequence of his independent **and unreasonable** action." [emphasis added]

132 Was then the decision of PD to have the second child with her consequent injury (in terms of post-incapacity cost of child care) not just the consequence of her independent action, but itself unreasonable action on her part? For reasons I explain, though indubitably the result of her independent, and indeed fully informed decision, it was not an unreasonable action on her part and from her viewpoint to choose to have a second child. In those terms, there was no *novus actus interveniens* in that decision and subsequent conduct.

133 However, that still leaves the further question in assessing whether the respondent **should** recover, namely the appropriate scope of liability for the consequences of tortious conduct; in short, the scope of the duty. That question is resolved by determining whether in normative terms it would be unjust to hold the appellants legally responsible for that further decision to have a further child, reasonable though it was from PD's viewpoint to do so. That question is not answered simply by invoking the principle that a

plaintiff takes a defendant as he find her; compare *Nader v Urban Transport Authority* (1985) 2 NSWLR 501.

134 PD must be taken to have known that before the child reached mature age she, PD, would be incapacitated from looking after her child. This is so whether that age be 12 as the trial judge held or earlier as PD unsuccessfully argued. While the doctor's negligence did not therefore directly lead to the decision to have the second child or remove PD's capacity to make a reasonable decision in that behalf, nonetheless, but for the doctors' negligence, she could have had a further child without fear of incapacity and consequent need for child care. In causal terms, the link can be said to be more attenuated between the original negligence and the particular head of damage here claimed. That attenuation, while not removing the necessary causal link, is a factor in considering the proper scope of the duty.

135 The following observations of Mason P in *Sullivan v Gordon* remain pertinent:

> "The birth of children is also linked to the accident, in a sense, because the appellant's brain damage impacted upon her ability to determine whether it was appropriate or responsible or sensible for her to have children (see at [67] of Beazley JA's reasons). I incline to the view that it would make no difference if this unusual link were absent, but I express no final view on the matter. An injured plaintiff's own need for personal care includes changing needs occurring throughout his or her lifetime. **Nevertheless, it may be necessary to consider whether it is always reasonable to lay at the tortfeasor's door the cost of care for children born after the injury. Pure logic is not the only matter at play in this difficult area of the law**." [emphasis added]

136 One such factor is that there is a **legal** obligation to care for children, as Mason P recognised. That may be compared to the **moral** obligation to care for an aged relative, important though that may be. A similar legal obligation applies here to PD. It cannot be said, contrary to the cross-respondent's submissions, that admitting such a claim ignores the role which the father of the child would play in providing for the care of the children. That role is likely to be a limited one, if PD remains in Australia. The trial judge found the father would be unlikely as an HIV positive person to be permitted to reside permanently in Australia, so his capacity to provide care cannot be counted upon.

137 Nor could it be said that there was a failure to mitigate her damage in the sense that the law requires, namely, that PD not act unreasonably in the circumstances, so as to bring about an increase in the damage she suffered. The burden is of course on the defendant to prove that the plaintiff's refusal to mitigate was unreasonable; Fleming "Law of Torts" (LBC, 1998) 9th ed at 286, approved by the Privy Council in *Geest plc v Lasinquot* [2003] 1 All ER 383. I have already concluded that she did not act unreasonably in exercising her choice to have a second child. It must be kept in mind that she had just turned 24 when she first consulted Dr Harvey with FH and would have had every expectation of having children. PD was a woman of childbearing years who, but for the doctor's negligence would have had every expectation of having a family with no fear of incapacity inhibiting that choice.

138 One way of posing the issue of the appropriate scope of the appellants' legal responsibility, translated into what loss should be recoverable, is to pose this question. What if PD had considered herself forced by the risks to hold back from having a further child? She might well have done so for fear of the risk of an HIV positive child, a risk apparently not capable of being totally eliminated, though it did not come home here. This could be coupled with a prudential concern about her not being incapacitated by HIV AIDS at a later date while the second child was still dependent. Then one would be considering a claim for loss of what I still assume to be the freedom **safely** to have a further child, in a very approximate sense the converse of a defective sterilisation. (Whether it is also a **right** is not necessary to decide.) An award of damages for pain and suffering from that deprivation might then plausibly be claimed. The argument would then run that the negligent doctor should not be advantaged by PD's willingness to undertake the risks involved in exercising her right to have a further child. Therefore, it would be said, she should recover the extra cost of childcare after her anticipated incapacity. That would be the equivalent to her damage if she had been forced to hold back from having the second child by reason of the risks for the child and her incapacity to look after it once she was incapacitated.

139 One answer is that the head of damage for pain and suffering from being deprived of further children is not the equivalent of the head of damage for cost of childcare after PD's anticipated incapacity by the time the child turns 12, or the equivalent of loss of capacity to care for a child after it turns 12. Moreover there is already an overlap in the claim for lost future earnings (including the lost years) which were assessed on the basis of PD being in fulltime employment. Finally, while in logic the two situations may appear the converse or reciprocal of each other, this is only in a very approximate sense. It by no means follows that because it may be justified to award damages for being deprived of the capacity safely to have children, damage should also follow when the risk of having further children has been safely circumvented.

140 Ultimately this way of looking at the problem tells against PD's recovery. This is because it opens up the very considerations which in analogous cases pose such difficult issues of recovery. Though the damage is not in the fullest sense to an indeterminate class, it would in its implications open up liability for a potentially indeterminate amount as well as other questions of indeterminacy. It raises the question of just how many children should be potentially within the ambit of damage recovery, given that each later birth would involve an ever longer anticipated period of future incapacity till the child turns 18. Suppose indeed PD's precautions were to fail and she were to have a child that was HIV positive. Could she then recover a further head of damage based upon the additional care obligation for the child that this would entail? What of recovery by the child itself? It is true that this has not occurred and therefore the example is hypothetical. But it illustrates the difficulty of extending liability for the cost of care for the second child or loss of capacity to care for that child, and laying this at the door of the doctors; by what principle, consistently applied, can this be justified?

141 It is true that unlike the sterilisation cases, one can quantify the cost of child care after the age of 12, though a claim for loss of capacity to care for a child is not simply measured in that way as Ipp JA points out in his judgment. Sterilisation cases by contrast present the problem of putting "*a price on the value to the parent of the new life*" (per

Hayne J at 200 in *Cattanach v Melchior*). That in the majority view was not ultimately an impediment in this country. In the United Kingdom the opposite result was reached (*McFarlane v Tayside Health Board* [2000] 2 AC 59, followed though not completely, as to the cost of a disabled child in *Rees v Darlington Memorial Hospital NHS Trust* [2003] UKHL 52). That these two ultimate courts of appeal, and by majority, reached such a contrary result, by reasoning inherently plausible, points to those competing legal concerns lying at the heart of this difficult issue as having no pre-ordained resolution; see Cane "The Doctor, the Stork and the Court; a Modern Morality Play" in (2004) 120 LQR 23. But here the considerations to which I have earlier referred do point to a high degree of indeterminacy of liability which tells strongly against extending liability.

142 Ultimately, whether one puts the matter in neutral terms of "legal concerns" (Jane Stapleton's preferred terminology in "The Golden Thread at the Heart of Tort Law" (2003) 24 Australian Bar Review 135 at 136) or in the more influential sense of "legal policy", albeit still awaiting final recognition as binding principle, I consider that the trial judge was correct in denying this further item of damage. I do so not because I consider that there is no causal link between original negligence of the doctors and later injury suffered in loss of capacity to care for a second child after it turns 12. The doctors were undoubtedly historically involved in that injury. Rather, I do so because I consider that this causal link is too attenuated and its quality altered in a normative sense by PD's independent decision to have the further child, knowing of her condition. Reasonable as it was from her viewpoint to do so, it is unreasonable to hold the doctors legally responsible for its financial consequences.

143 Another most important consideration bearing on that unreasonableness is that recovery would bring about the possibility of far-ranging if not indeterminate liability. As was said by Gleeson CJ in *Perre v Apand Pty* Ltd [1999] 198 CLR 180 at 189 ([5]):

> "….. bearing in mind the expansive application which has been given to the concept of reasonable foreseeability in relation to physical injury to person or property, a duty to avoid any reasonably foreseeable financial harm needs to be constrained by 'some intelligible limits to keep the law of negligence within the bounds of common sense and practicality'." [omitting footnotes]

144 In *Cattanach* the majority gave the greatest weight to "*the increasing judicial aversion to the enjoyment of special privilege or advantage in litigation unless strong reason for its creation or retention can be justified*" (per Callinan J at [295]. Neither *Cattanach* nor this case confer a blanket immunity upon a category of defendant like police in the carrying out of their duties. Rather the special advantage lies in denying "*recovery of a particular head of damages for an admitted breach of duty*" (per McHugh and Gummow JJ at [59] in *Cattanach*). But unlike *Cattanach* which was a claim for recovery of pure economic loss, we are here dealing with a claim for financial loss consequential upon personal injury to the plaintiff, a distinction drawn by Gleeson CJ in *Cattanach*.

145 In reaching this conclusion, I frankly acknowledge the part played by a concern which could now fairly be described as one of legal policy if not yet legal principle, namely that of indeterminacy. I should do so explicitly rather than mask what I am doing

by mere labelling. The legitimacy of doing so is affirmed by Callinan J in *Cattanach* (at [291]). It is exemplified in the earlier quoted passage from the Chief Justice in *Perre v Apand* (supra).

146 McHugh and Gummow JJ in *Cattanach* at [58] to [82] articulate what is meant by legal policy. They contrast it with what they term a more expedient or ephemeral public policy. At [84], speaking of it, they emphasise that "*The policy of the law should be slow to fix upon something 'inherently fluid'*", citing the extra-judicial writings of Lord Radcliffe for that distinction between legal and public policy.

147 Here there is nothing inherently fluid, or expedient, in recourse to longstanding community concern about indeterminate liability, reinforced by burgeoning costs of the Insurance industry. "*If the appellants are said to be subject to an indeterminate liability, that is important to the question of the existence of their duty of care*" (Gleeson CJ in *Cattanach* at [26]). That stricture is especially apposite when read with his earlier warning, applicable here, that "*the modesty of a claim as presented in a particular case might lead a court to overlook the implications, for other cases, of the acceptance of a claim of that character*" (at [20]). There are here strong considerations of legal policy which, with increasing appellate recognition and refinement tested by a sufficiency of cases, may yet acquire the binding character of principle. These, with the factor of PD's informed decision to have a second child emphasised by Spigelman CJ and Ipp JA in their judgments, point strongly against legal recovery. While therefore I believe that they produce a result rather less finely balanced than *Cattanach*, it behoves a judge drawing in part on legal policy in this relatively novel area to avoid undue dogmatism. This is more especially as indeterminacy is itself a matter of degree, though the degree here is considerable.

OVERALL CONCLUSION

148 I consider that this appeal should fail as also the cross-appeal. Accordingly, I would order that the appeal be disallowed with costs and the cross-appeal likewise disallowed with costs. But I would defer the coming into effect of the latter orders for 14 days to enable the parties if they so choose to make further submissions on costs.

149 **IPP JA:** I have had the benefit of reading the reasons to be published of Santow JA. I set out below my reasons for agreeing with the orders proposed by his Honour. I turn firstly to the appeal.

The alleged breaches of the duty of care

150 The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. The duty extends to the provision of information in an appropriate case: ***Rogers v Whitaker*** (1992) 175 CLR 479 at 483. Dr Harvey undoubtedly owed PD a generalised duty of care that extended to the provision of information. The extent or scope of that duty is in issue.

151 I shall deal only with three of the respects in which PD contended that the appellants breached the duty of care that they owed her, namely:

(a) The appellants failed to inform PD that FH was HIV positive.

(b) They failed to provide adequate pre-test counselling to PD and FH and failed to determine what each intended to do if one or the other was found to be HIV positive.

(c) They failed to counsel PD personally when she attended to receive her test results or arrange for a doctor to counsel her.

The relevant circumstances

152 In 1997 or early 1998 PD met FH. He was a national of Ghana who had entered Australia on a temporary visitor's visa. Their friendship developed into a close relationship and they had sexual intercourse. At that stage, they always took prophylactic measures and only protected sexual intercourse took place between them.

153 In October 1998, FH proposed marriage to PD and she accepted on condition that they first, "together", underwent tests for sexually transmitted disease ("STD tests"). FH agreed.

154 PD had been a patient of the Alpha Medical Centre ("the Centre") since October 1997. On 16 November 1998 she, together with FH, went to the Centre. They were shown into a room where they met Dr Harvey. PD had not consulted Dr Harvey previously.

155 Dr Harvey was sitting behind a desk. PD and FH sat next to each other on a couch opposite him. They were holding hands. According to Dr Harvey, they appeared to be "slightly embarrassed". PD said:

> "We are here to perform an HIV test, blood test and also Hepatitis and Hepatitis B, and just general STD checks."

156 Dr Harvey testified that they explained to him that they wanted to have STD tests "because they were about to begin a new relationship, or about to engage in a new relationship". In cross-examination, it was put to Dr Harvey that the consultation involved a couple that attended together "with a view to eliminating the possibility of STDs". He agreed.

157 Dr Harvey first asked PD some questions. He asked if she had ever used any intravenous drugs. She replied in the negative. He asked if she had ever engaged in anal sex and she again replied in the negative. He asked about her general health and she replied that her general health was good. He asked her whether she thought that she was at a high risk of contracting sexually transmitted diseases and she said that she had never used heavy drugs or "anything like that".

158 Dr Harvey then addressed the same questions to FH, including whether he had used any intravenous drugs or had engaged in anal sexual intercourse. FH answered each of these questions in the negative. He said his general health was good. Dr Harvey asked

him what country he came from and he replied: "Ghana". Dr Harvey then asked FH "about genital ulceration and groin nodes". He said he did this because "there are three STD's which are associated with people from tropical countries". FH answered these questions in the negative.

159 Blood samples were taken for testing. PD asked Dr Harvey when the results would be available and he said "in one to two weeks time". Dr Harvey told them to "come back" to get the results.

160 Within two weeks PD returned to the Centre and spoke to the receptionist. The receptionist gave her a copy of the pathology report relating to herself. PD asked for FH's pathology report but the receptionist said that that was confidential and could not be given to her. Unbeknown to PD, the Centre had received pathology tests that showed FH to be HIV positive.

161 PD told FH that she had received her test results and they were negative. He said he had received his as well and they were also negative. She was not satisfied with that and asked to see his results. He tried to fob her off but she persisted. He then showed her a false copy of his results that indicated that his tests were negative. This false report deceived PD and stilled her doubts. She married FH, became pregnant by him, and later discovered that she had contracted HIV.

162 The evidence of an expert witness, Dr Carmella Law, who gave evidence on behalf of PD, needs to be mentioned. Dr Law testified that, "an HIV test should never be performed without pre-test counselling". She said that the "joint session" with PD and FH would "provide an opportunity to check the couple's preferences on how they are going to obtain their results i.e. jointly or separately" and how "they would manage the situation if one or both of them were to turn out to be positive". She said that a medical practitioner in the position of Dr Harvey should "[make] sure the client has an appointment to return to pick up the results in person". In cross-examination she said that should a couple consult her with a view to obtaining STD tests she would ask them specifically, "[a]re you happy to be in the presence of each other when you get the test results?" She said:

> "[M]ost of the time when they attend together for a test they want the test together, that's the whole idea about doing this together."

In context, the reference to "a couple" wanting the test together meant that they wanted the test *results* together.

Tacit consent by FH to the disclosure of his test results and Dr Harvey's breach of the duty of care

163 I turn now to the question whether the duty of care owed by Dr Harvey to PD extended to telling her that FH 's STD test results were positive. The answer to this question would be straightforward, but for ss 17(2) and (3) of the *Public Health Act* 1991 (NSW) (the "Act"). This needs some explanation.

164 HIV infection is a "Category 5 medical condition" under the Act (s 3(1)). Section 17(2) provides that a person who, in the course of providing a service, acquires information that another person has been infected with a Category 5 medical condition, must "take all reasonable steps to prevent disclosure of the information to another person". Section 17(3)(a) provides, however, that information of the kind to which s 17(2) applies may be disclosed "with the consent of the other person".

165 The effect of these sections is that Dr Harvey could only disclose FH's test results to PD if FH consented.

166 Section 17(3)(a) is to be contrasted with s 42J of the Act. Section 42J concerns the disclosure, in conjunction with the result of a cervical cancer test, of the identifying particulars of any woman who underwent such a test. Section 42J(1)(b) provides that a person may disclose such information only "with the written consent of the woman". In contrast with s 17(3)(a), s 42J(1)(b) requires the consent to be in writing.

167 Another section in the Act, of less significance in the present context, but nevertheless relevant, is s 61L(1). This section provides:

> "Proceedings for an offence against this Division … are not to be commenced without the consent in writing of the Director-General or a person authorised by the Director-General in writing for the purposes of this section."

168 The point to be made is that the Act distinguishes between consents that are required to be in writing and consents that require no formality. The consent required under s 17(3)(a) falls into the category requiring no formality; nothing in the Act precludes a consent in terms of s 17(3)(a) from being given tacitly.

169 Cripps AJ, in dealing with the issue of consent, said:

> "An issue has been raised whether I should conclude that in fact FH, by reason of the joint consultation and the way it was conducted, gave his consent for his results to be passed to PD. However, the matter was not discussed at the joint consultation. Neither FH nor PD raised with the doctor, or he with them, whether they consented to information relating to one being available to the other … Accordingly I find that FH did not give his consent to Drs Harvey and Chen to disclose his result to PD."

170 With respect to his Honour, the reasons given do not address the point. The mere fact that the issue of consent did not expressly arise at the consultation says nothing about whether consent was tacitly given.

171 Due significance must be accorded to the fact that PD and FH saw Dr Harvey together, and asked him, together, to be tested for HIV. One must ask: what was the purpose in the two of them going to see Dr Harvey *together* about being tested for HIV?

The answer given by Dr Law springs immediately to mind: most of the time, when a couple attend together on a medical practitioner for the purposes of obtaining STD tests, they want to get the results together, “that’s the whole idea [of] doing this together.”

172 This inference was supported by other circumstances. Dr Harvey acknowledged that at November 1998 he knew that there was an elevated risk of HIV in people from Ghana as compared to the Australian population. PD knew that HIV was a serious problem in Africa and that was one of the reasons for her insistence on the STD tests before she would agree to unprotected sex. She had made this clear to FH. The prevalence of HIV in Africa appears to have been well-known. Thus, all three persons at the consultation knew that there were more pressing reasons than the normal in this country for PD to be assured that FH had a clean bill of health before agreeing to their “new” relationship. This increased the significance of the joint nature of the consultation.

173 The conduct of PD and FH throughout the consultation showed that each regarded the need to discover whether either of them had contracted STDs, generally, and HIV, in particular, as being of the utmost importance to both of them. This was not surprising since they had made it plain to Dr Harvey that they were about to engage in or begin a new relationship, which would involve sexual intercourse, such that each would be vulnerable to infection if the other was already infected.

174 Dr Harvey had no difficulty in asking each, in the presence of the other, a series of questions that concerned potentially life-threatening issues of the utmost sensitivity, intimacy and privacy. The answers to these questions would ordinarily have been confidential to the highest degree. I have mentioned the questions that concerned risks in lifestyle, drug use, anal sex, and groin lesions. Dr Harvey did not feel the need to ask whether either of PD or FH would mind being asked these questions in the presence of each other. He must have understood from the conduct of PD and FH that each consented. This understanding must have been confirmed when each answered these questions readily and candidly.

175 The willingness of PD and FH, despite being embarrassed by the occasion, to disclose information in the presence of each other about these matters was obviously due to a strong desire to learn whether it would be safe for them to engage in the new relationship contemplated. This knowledge was crucial to the health of each and could become a matter of life or death. The same considerations applied to the STD results. The inference is that PD and FH were equally willing for there to be mutual disclosure of these results.

176 Accordingly, in my view, PD and FH each tacitly consented to the disclosure by Dr Harvey of the results of the STD tests to the other.

177 Further, in my view, all these circumstances lead to the conclusion that Dr Harvey (and Dr Chen who was vicariously liable for Dr Harvey’s conduct) breached his duty of care by failing to disclose to PD that FH was HIV positive.

178 I would uphold the Notice of Contention.

179 In any event, if FH did not tacitly consent to Dr Harvey disclosing his test results to PD, then the duty of care owed by Dr Harvey must have extended to requiring him to inform PD and FH, at the consultation of 16 November 1998, of the effect of ss 17(2) and 17(3) of the Act, and to ascertain their wishes as to the disclosure of the test results.

180 Cripps AJ found that:

> "If FH were not prepared to have his results made available to her she [PD] would have discontinued her relationship with him."

Santow JA concludes that had Dr Harvey, at the initial consultation, addressed the question of mutual disclosure of results and the possibility of discordant results, Dr Harvey would have secured the consent of FH to his results being disclosed to PD. Were FH to have refused, PD would have terminated her relationship with FH. Santow JA observes:

> "In either case, PD would have escaped the injury she suffered because FH would not have been in a position to deceive her."

I agree with his Honour.

The causation issues: the two-limbed test

181 It was argued on behalf of Dr Harvey and Dr Chen that there were two "supervening causes" that prevented their negligence from being a legal cause of PD's loss.

182 The first was the fact that the Centre's receptionist told PD that she was not entitled to a copy of FH's pathology report. Despite being informed that she could not have access to FH's STD results, PD decided, of her own accord, without any input from the appellants, to have unprotected sex with FH. This "independent" decision, it was said, broke the chain of causation.

183 The second was FH's deception of PD. It was said that this deception was a matter for which the appellants bore no responsibility and this too broke the chain of causation.

184 Both these arguments raise the issue of the test to be applied when some independent act of a third party or a decision by the plaintiff materially contributes to the loss sustained.

185 ***March v E & M H Stramare Pty Limited*** (1991) 171 CLR 506, ***Medlin v State Government Insurance Commission*** (1995) 182 CLR 1 and ***Henville v Walker*** (2001) 206 CLR 459 indicate that terminology such as "*novus actus interveniens*" and "breaking the chain of causation" is no longer appropriate in determining the effect that the act of an

independent third party, or the plaintiff herself, might have on whether responsibility for the plaintiff's loss is to be attributed to the defendant.

186 Very often, issues of legal causation may be resolved simply by the application of the "but for" test. This is usually where the issue of causation is a simple one. But, in some circumstances, the "but for" test is inappropriate.

187 In more complex cases of causation, a two-limbed test is to be applied. The first limb entails the question whether the defendant's conduct is historically involved in the plaintiff's loss. The second limb requires the question to be asked: *ought* the defendant be held liable for the harm sustained: ***Ruddock v Taylor*** [2003] NSWCA 262 at [87]. The second question involves a normative weighing of all the relevant circumstances.

188 Thus, there is no single issue that is determinative. Once historical involvement is established, the chain of *factual* causation cannot be broken. Factual causation, however, does not alone establish legal causation. There is no such factor as a *novus actus interveniens* that is determinative of legal causation, although considerable significance will usually be attributed to a single cause that materially contributes to the loss after the defendant's tortious conduct has taken place. The question remains, however, one to be determined by having regard to all the circumstances and then making a value judgment.

189 In ***Tambree v Travel Compensation Fund*** [2004] NSWCA 24 Sheller JA (with whom Mason P and I agreed) undertook a careful examination of ***March v Stramare***, ***Medlin v State Government Insurance Commission*** (1995) 182 CLR 1 and ***Henville v Walker*** and applied the two-limbed test.

190 This approach has most recently been reiterated by Hayne J in ***Pledge v Roads and Traffic Authority*** (2004) HCA 13, where his Honour said (at [10]):

> "The questions that are relevant to legal responsibility are first, whether, as a matter of history, the particular acts or omissions under consideration (here the acts or omissions which led to the presence of the foliage, and the parking bays, and the absence of warning signs) *did* have a role in the happening of the accident. It is necessary then to examine the role that is identified by reference to the purpose of the inquiry – the attribution of legal responsibility … . It is at this second level of inquiry that it may be necessary to ask whether, for some policy reason, the person responsible for that circumstances should nevertheless be held not liable [Stapleton, 'Unpacking 'Causation', in Cane and Gardner (eds), *Relating to Responsibility*, (2001) 145 at 166-173]."

191 In my view, the two-limbed test should be applied in this case.

Application of the two-limbed test

192 The negligent conduct of Dr Harvey was undoubtedly an historical cause of PD's loss. In regard to both of the appellants' arguments, it is the second limb that is contentious.

193 Cripps AJ noted that it was common ground that PD should not have received her results from the receptionist but should have received them from a medical practitioner. It is not entirely clear to me whether this means that the appellants conceded that Dr Harvey was negligent in failing to counsel PD personally when she attended to receive her test results or to arrange for a doctor to counsel her. In any event, however, I consider that Dr Harvey was indeed negligent in this respect.

194 I doubt that accepted medical practice has descended to the level where receptionists customarily are allowed to disclose potentially life-threatening information to patients in a mechanical, routine and unfeeling way. Whatever the position may be in this regard, in the particular circumstances of this case, Dr Harvey was duty bound to inform PD, personally, of the STD results. He breached this duty.

195 The receptionist's reply to PD was likely to have caused PD to believe that it was hopeless to try to obtain FH's STD results from Dr Harvey. She was then compelled to rely on the integrity of FH. Thus, the breach of duty on the part of Dr Harvey, in failing to speak to PD personally when she came to find out what her own, and FH's, test results were, or to arrange for another doctor to see her, made her vulnerable to FH's fraud.

196 FH's deception of PD falls into the same category. Dr Harvey's breach of duty in failing to provide the appropriate information to PD enabled FH to deceive PD into believing that his test results were negative. Dr Harvey's conduct was an essential springboard for FH's fraud.

197 In these circumstances, I consider that it would be quite wrong to allow the appellants to rely on Dr Harvey's breaches of duty so as to defeat causation.

198 I would therefore dismiss the appellants' appeal.

The cross-appeal

199 I turn now to the cross appeal. The grounds of the cross appeal are as follows:

> "(1) His Honour erred in failing to award damages based on **Griffiths v Kerkemeyer** (1977) 139 CLR 161 and **Sullivan v Gordon** (1999) 47 NSWLR 319 in relation to the plaintiff's second child.
>
> (2) His Honour erred in finding that 'a link must be established' before damages in the nature of **Sullivan v Gordon** could be awarded.
>
> (3) His Honour erred in finding that a link was 'wholly absent' in the birth of the plaintiff's second child."

200 Before addressing the issues raised by these grounds, there are, I think, some comments that need to be made.

Not a claim for cost of child-care

201 Firstly, the head of damage, the subject of the cross appeal, is a claim for the loss of capacity to care for others. This head of damages is related to damages for gratuitous care awarded under the principle in ***Griffiths v Kerkemeyer*** (1977) 139 CLR 161: see ***Sullivan v Gordon*** (1999) 47 NSWLR 319; ***CSR Limited v Thompson*** [2003] NSWCA 329. This means that the loss being compensated for is loss of *capacity* rather than financial loss as such.

202 Therefore, this claim is not a claim for costs of child-care and should not be described as such.

The measure of a *Sullivan v Gordon* loss

203 In claims for ***Griffiths v Kerkemeyer*** damages, the generally accepted rule is that the damages under this head are measured by the market cost of providing the services: ***Van Gervan v Fenton*** (1992) 175 CLR 327.

204 In straightforward ***Griffiths v Kerkemeyer*** claims, the market cost of services is an obvious measure of the plaintiff's need for them. But the same is not necessarily the case in regard to ***Sullivan v Gordon*** damages for loss of capacity to care for others. This is particularly so when, at the time the loss is incurred (ordinarily, at the date of the tort) the plaintiff was not in fact caring for anyone else and had no need to do so.

205 Take the notional example of a plaintiff who, prior to the tort, has a full-time income-earning occupation and who employs a full-time carer to look after her child. The loss of her capacity to care for her child would not then be measured by the actual cost of caring for the child. In those circumstances that cost would merely be an expense to be met out of the damages awarded for the plaintiff's loss of earning capacity. In the case of a married plaintiff whose spouse is the full-time carer of their children, loss of capacity to care for the children is unlikely to be sustained. Where such a plaintiff spends only part of his or her time caring for the children, the loss of capacity would have to be measured by reference to that part alone. Similar considerations apply to a plaintiff who, prior to the loss of capacity, works part-time and employs a professional carer to look after the children.

206 It would not be correct, therefore, to assume that the measure of damages for loss of capacity to care for others is inevitably the entire cost of caring for the child. For reasons that I later express, this becomes a relevant factor when considering the normative causation question that arises in the cross-appeal.

Not mitigation of damages

207 During the course of argument and, indeed, at trial, there was some suggestion that PD's decision to have a second child constituted a failure to mitigate her damages. That, however, is an erroneous approach to the question.

208 I have observed that Dr Harvey's tortious conduct, as a matter of historical involvement, materially contributed to PD's capacity to care for her second child. Her decision to have a second child can have no bearing on that fact. It is merely a matter to be taken into account in addressing the second limb of the two-limbed test for causation. The question is whether, as a matter of normative judgment, PD's decision precludes a finding that, in law, the appellants' tortious conduct was a cause of her loss of capacity. The issue is one of causation, not mitigation of damage.

The "right to procreate" and the "freedom to procreate"

209 In his reasons Santow JA observes that the proposition that a common law right to procreate exists was mentioned, obiter, by Beazley JA (with whom Spigelman CJ, Powell JA and Stein JA agreed) in ***Sullivan v Gordon*** at 335. Her Honour said:

> "[I]t is probably the case that there is a common law right to procreate: see **Re 'Jane'** (1988) 94 FLR 1; see also art 23(a) of the *International Covenant on Civil and Political Rights*."

210 In ***Sullivan v Gordon*** the Court made no reference to ***Secretary, Department of Health and Community Services v JWB and SMB (Marion's Case)*** (1992) 175 CLR 218. In that case Mason CJ, Dawson, Toohey and Gaudron JJ referred to ***Re "Jane"*** and said (at 254) that they would leave open the question whether "there exists in the common law a fundamental right to reproduce which is independent of the right to personal inviolability". Their Honours observed (also at 254):

> "It is debatable whether the former [a common law right to reproduce] is a useful concept, when couched in terms of a basic right, and how fundamental such a right can be said to be … For example, there cannot be said to be an absolute right in a man to reproduce (except where a woman consents to bear a child), unless it can be contended that the right to bodily integrity yields to the former right, and that cannot be so. That is to say, if there is an absolute right to reproduce, is there a duty to bear children? But if the so-called right to reproduce comprises a right not to be prevented from being biologically capable of reproducing, that is a right to bodily integrity. The same applies, though in a different way, to a woman's 'right to reproduce'. Again, if the right is, in fact, a right to do with one's person what one chooses, it is saying no more than that there is a right to bodily and personal integrity. Furthermore, it is quite impossible to spell out all the implications which may flow from saying that there is a right to reproduce, expressed in absolute terms and independent from a right to personal inviolability."

211 Many virtually insoluble questions relate to the recognition of a common law right to procreate or reproduce. One may ask: when does that right accrue? Could it be said to accrue on puberty? In this country the vast majority of parents of a girl of that age would, I think, be appalled at the suggestion that such a right might then accrue. If it arises later, how is the age of accrual to be ascertained? Another difficult question is: what relevance to this notional right has the woman's ability to support the child financially – or even

emotionally? Does a woman have that right even if she is not equipped to be an appropriate mother to the child? Does a woman who has abandoned or abused a child in the past forfeit that right for the future? Would the right apply indefinitely, no matter how many children to whom the woman gives birth? The average number of children in two-parent households in Australia is 1.9, and 1.6 for one parent households: *Family Characteristics Australia*, Australian Bureau of Statistics, 1998. Some women have ten children or more, do women have an absolute right to reproduce to this extent and more? For my part, I do not accept such a proposition.

212 ***Marion's case*** and the difficulties to which I have adverted demonstrate, in my view, that it is quite unhelpful to speak of a common law right to procreate in the present context.

213 In his reasons Santow JA assumes that parents have "the freedom to choose to have a further child". I accept that PD was "free" to have a second child. That "freedom", in my view, does not determine whether the appellants should be held liable for PD's loss of capacity to care for that child.

The capacity of a plaintiff to decide whether to have children

214 In ***Sullivan v Gordon*** the tortious conduct of the defendant led to the plaintiff sustaining frontal lobe damage. Beazley JA said in this regard (at 334):

> "[T]he appellant's brain damage reduced her ability to determine whether it was appropriate or responsible or reasonable for her to have children, either at all or in the circumstances in which she conceived and bore these children. The appellant's conduct in having children, even if it could be objectively viewed as unreasonable, was caused by the respondent's negligence and consequently there was no break in the chain of causation."

215 Mason P commented at 324:

> "The birth of children is also linked to the accident, in a sense, because the appellant's brain damage impacted upon her ability to determine whether it was appropriate or responsible or sensible for her to have children … I incline to the view that it would make no difference if this unusual link were absent, but I express no final view on the matter. An injured plaintiff's own need for personal care includes changing needs occurring throughout his or her lifetime. Nevertheless, it may be necessary to consider whether it is always reasonable to lay at the tortfeasor's door the cost of care for children born after the injury. Pure logic is not the only matter at play in this difficult area of the law."

216 Some point of distinction was sought to be drawn between ***Sullivan v Gordon*** and the present case on the ground that, unlike the plaintiff in ***Sullivan v Gordon***, the negligence of the appellants did not cause any injury to PD's cognitive capacity.

217 In my view, there is a relevant distinction, but it has to be understood in context.

218 It is first necessary to reiterate that we are dealing here, again, with a causation issue that requires the application of the two-limbed test – this time to grounds two and three of the cross-appeal.

219 The second ground of the cross appeal is that the judge erred in finding that "a link must be established" before damages in the nature of ***Sullivan v Gordon*** could be awarded. That "link", in the context of his Honour's reasons, meant a link between the negligence of the appellants and the decision to have a second child.

220 Cripps AJ held that, according to ***Sullivan v Gordon***, such a link must be proved before damages for loss of capacity to care for a child can be established. That, however, is not my reading of the judgment of Beazley JA in that case. Her Honour certainly emphasised the importance of the brain damage that the defendant in that case had caused. But this was in the context of determining whether there had been a "break in the chain of causation". Thus, in the circumstances of that case, the brain damage was a highly significant consideration. But the inability to make an informed decision whether or not to have children is not an essential condition to the right to recover ***Sullivan v Gordon*** damages (see in this regard the comments of Mason P referred to above).

221 Again, the two-limbed test for causation illuminates the position.

222 It is a trite proposition that there must be a causal link between the tortious conduct and the damages incurred (whether in the nature of ***Sullivan v Gordon*** damages or otherwise). To this extent, the judge was plainly correct in finding that "a link must be established" before ***Sullivan v Gordon*** damages could be awarded. But the link needed is not a link between the negligence of the appellants and the decision to have a second child. Instead, it is a link establishing legal causation.

223 The third ground of the cross appeal is that the judge erred in finding that the link between the tortious conduct and the decision to have the child was "'wholly absent". As a matter of fact, his Honour cannot be faulted in this finding. But, as I have stated, that does not conclude the causation issue. While there is no doubt that there was an historical involvement between the negligence of the appellants and the ***Sullivan v Gordon*** loss suffered by PD, a live question remains in regard to the second limb of the two-limbed test. That is, the normative question whether, having regard to all the circumstances and, in particular, PD's fully informed decision to have a second child, has causation recognised by the law been established?

224 In answering this normative question, the capacity of PD to make an informed decision plays a considerable, but not necessarily conclusive, part.

The normative question: the second limb of the two-limbed test

225 This question requires several factors to be weighed in the balance.

226 PD’s second child was conceived when she already had one child, and when she knew that she was infected with HIV, that her capacity to look after children was reduced, that the father of the second child was also infected with HIV and that he was unlikely to be allowed to stay in Australia permanently.

227 PD’s fully informed decision to have a second child has considerable causal potency, but there are other factors, also of a normative kind, that, in my view, must also be taken into account.

228 Cripps AJ said that the circumstances relating to PD’s relationship with the father of her second child were “not really explored during the proceedings”. It is not entirely clear whether the father has made or will make any contribution to the costs of looking after the child, but that seems less than likely. There is no suggestion in the evidence that I have been able to find to the effect that such a contribution has been or might be made. The claim seems to have been put on the basis that the entire expense is recoverable from the appellants. The evidence given by PD on this issue was to the effect that her salary was the only source of income that she could use for the child.

229 It may be said that the reservoir of men from whom PD was able to choose a life partner or a sexual partner has been limited by the appellants’ negligence. However, the evidence does not establish that it was so limited as to compel her to acquire, as such a partner, an overseas resident – precluded from gaining permanent entry into Australia – and who does not contribute to the expense of bringing up his own child.

230 I reiterate that the claim is for loss of capacity, and in assessing such loss account is taken of the need of the plaintiff to care for the child. In the ordinary course, the father will contribute to the cost of bringing up the child (and will be required, by law, to do so). In that event, the father’s contribution will reduce the mother’s need.

231 Accordingly, in my view, the appellants could not be held liable for loss of capacity measured by reference to the entire cost of bringing up the child. Fairness requires those costs to be excluded which, in the ordinary course, would have been borne by whoever might have been the father of the child (but which in fact will not be so borne – because of PD’s deliberate decision to have a child by a man who lacks the ability to contribute to the child’s welfare).

232 The question is whether the appellants should be held liable for a lesser amount.

233 I would add that, in this particular case, the child faces a more difficult future by reason of the fact that, as is the case with his mother, his father has a reduced expectation of life and, moreover, is likely – throughout his lifetime – to be absent from the family home for long periods. In my view, the law should not provide an incentive to children being born in such circumstances.

234 The social and moral questions that arise in this case become particularly pointed when one asks: assume that another defendant (in a similar position to the appellants) is faced with a claim for ***Sullivan v Gordon*** damages where the plaintiff has given birth to two, or three, or four children for whom she cannot properly care because of loss of

capacity on her part. How then is the loss of capacity to be measured? The mind baulks at the prospect of the cost of raising all such children being taken into account. As Santow JA asks:

> "[J]ust how many children should be potentially within the ambit of damage recovery, given that each later birth would involve an ever longer anticipated period of future incapacity till the child turns 18."

235 In this context, Santow JA asks another telling rhetorical question:

> "Suppose indeed PD's precautions were to fail and she were to have a child that was HIV positive. Could she then recover a further head of damage based upon the additional care obligation for the child that this would entail?"

In my view, the law should not provide any encouragement to deliberate decisions to have children in circumstances where those children could at birth be infected with HIV.

236 These factors, in my view, collectively compel the normative question to be answered in favour of the appellants. I would dismiss the cross-appeal.