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# MEDICAL CONFIDENTIALITY AND CHALLENGES OF PROTECTING THE RIGHTS OF PERSONS LIVING WITH HIV AND AIDS IN NIGERIA

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*Abstract*

*In Nigeria, as in other parts of Africa, persons living with HIV/AIDS (PLWHAS) often experience discrimination and stigmatization by family or in the workplace, at school, and in other settings, including correctional centres and healthcare and religious institutions. As a result of this, many persons living with HIV/AIDS shy away from medical treatment and making their status known, owing to the fact that there have been repeated cases of breach of confidence on the part of the medical practitioners who care for the well-being of persons living with HIV/AIDS. The duty of healthcare professionals to keep a patient's information confidential in the course of treatment and care usually places them in a difficult position as a result of the need to balance the conflicting interest of confidentiality and disclosure. This work examined the principle of medical confidentiality and professional secrecy, the rights of persons living with HIV and AIDS to medical treatment as well as the challenges faced by healthcare professionals in the treatment of persons living with HIV and AIDS, including the duty to warn caregivers and third parties in appropriate situations. The authors found that because a conflict between the rights of persons living with HIV/AIDS to confidentiality and the rights of third parties, including the public, to be protected from harm exists, many healthcare providers are placed in a quagmire. The authors also identified some notable exceptions to the duty of confidentiality, juxtaposing them with the case of persons living with HIV/AIDS. While adopting a doctrinal approach to the topic; considering various authors and a number of cases, the work concluded by proffering recommendations, among which are the beneficial disclosure of sero status both by persons living with HIV/AIDS as well as healthcare providers, and the criminalisation in Nigeria, of deliberate, reckless conduct against medical advice, adjudged to be carried out by persons living with HIV/AIDS with the intent of infecting others.*

**Key words**: confidentiality, disclosure, discrimination, healthcare, rights

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*Introduction*

In Nigeria, as in other parts of Africa, persons living with HIV/AIDS (PLWHAS) often experience discrimination and stigmatisation by family or in the workplace, at school, and in other settings including correctional health care and religious institutions. As a result of this, many persons living with HIV/AIDS shy away from medical treatment and making their status known, since there have been repeated cases of breach of confidence on the part of the doctors or physicians who care for the well-being of persons living with HIV/AIDS. Medical information maintained by physicians is privileged and should remain confidential, as the right to privacy on the part of the patient is personal and fundamental.

However, where sensitive or privileged information is disclosed to a third party by the physician without specific authorization from the patient, it is then safe and correct to conclude that the right to privacy and confidentiality of the patient has been breached.[2]A confidential relationship between physician and patient is essential for the free flow of information necessary for sound medical care. Only in a setting of trust can a patient share the private feelings and personal history that enables the physician to comprehend fully, to diagnose logically, and to treat properly. The privileged nature of communication between physician and patient is a safeguard for the patient's personal privacy and constitutional rights. In Nigeria, after several years in the parliament, the HIV/AIDS Anti-Discrimination Bill 2014 eventually scaled through and passed into law on February 3, 2015. Notwithstanding the foregoing, persons living with HIV and AIDS have suffered all forms of stigmatisation, humiliation, discrimination and denial of rights. The law made provisions for the prevention of HIV-related discrimination and provides access to healthcare and other services. The Act also provides for the protection of the rights and dignity of persons living with HIV and those affected by AIDS in Nigeria.[2]

In an environment that is filled with stigma and discriminatory attitudes and practices against persons living with HIV and AIDS, such persons will likely have difficulty accessing information, counselling, and support services that would prolong their lives. They may also be reluctant to disclose their status to seek assistance for fear of repercussions. Indeed stigma, discrimination and lack of respect for human rights may also be a powerful disincentive for people to find out their HIV status through available voluntary counselling and testing (VCT) services, thus increasing the likelihood that infected individuals will unwittingly spread HIV. Stigmatisation and discrimination

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[2] American Academy of Family Physicians. <www.aafp.org> accessed on 3/09/15 [2]Onyekwere J., "HIV and AIDS Anti-Discrimination Law and Essence of Implementation".
*The Guardian*, 30th June, 2016.

may also lead to dangerous complacency in individuals and groups who are not targeted and therefore assume they are not at risk.[3]

The need to protect and promote the rights of persons living with HIV/AIDS is predicated on the standards contained in the Universal Declaration on Human Rights and the International Covenant on Economic, Social and Cultural Rights (ratified by Nigeria in 1993) and domesticated through the African Charter on Human and Peoples Right[4] and other international human rights instruments, such as the International Labour Organization (ILO) instruments concerning discrimination in employment and occupation, termination of employment, protection of workers privacy, and safety and health at work. Many of these rights are enshrined in Chapter IV of the Constitution of the Federal Republic of Nigeria (CFRN) 1999 (As amended).

The individual has the right to confidentiality and privacy in personal matters such as his health and sexual relationships. It is hinged on the right of the dignity of the human person and privacy as human rights. This is not only a legal issue, but also part of the moral values of the society as well as medical ethics. Without this right, it would be difficult for a patient to discuss his health problems with a doctor.[5] Confidentiality is an ethical principle relevant to the provision of healthcare. It encompasses the view that a person should be entitled to privacy concerning his or her most personal physical and psychological information. It is also part of the basis for the effective relationship between patients and healthcare providers, and hence the basis for the effectiveness of many public health interventions that rest on this relationship. A patient will only come forward and share information if he is sure that the healthcare provider will keep confidential any information that may be critical to making decisions about effective clinical care and treatment.

The principle of confidentiality however is not absolute in nature, as medical opinion, case law and legislation now admit that the obligation is qualified; it admits of certain limitations and exceptions. Confidentiality is not breached by private discussions with colleagues in pursuance of treatment, but may require the consent of the patient, which may be waived by the patient. A doctor may be required by law to make disclosure in which case no breach of confidentiality would be said to occur. In some cases, limited information may be permissible for purposes of statistics, accounting, data processing or other legitimate information. A doctor may also reveal confidences and secrets if he is required to present it before a court or tribunal, say if he has to defend himself or

[3] Iwuagwu S. et al, 'HIV/AIDS and Human Rights in Nigeria; Background Paper for HIV/AIDS Policy Review in Nigeria' (September 2003).
<Hivhealthclearinghouse.unesco.org.> accessed 4/09/15

[4] Ratification and Enforcement Act Cap 10 Laws of the Federation of Nigeria 2004 [5] Iwuagwu S. et al, Loc. Cit.

others against accusation or wrongful conduct. There are rare occasions when a doctor who receives information about a dangerous patient that can endanger the lives of others, would be expected to use good professional judgment to determine if there exists a need to warn at danger from the patient. Where a physician comes to the conclusion that there is a need for such warning, he must act without hesitation to prevent injury or loss of life even if that would amount to a breach of confidentiality.

This background evokes mind-boggling issues which agitate the minds of the researchers and raise salient questions for contemplation. For instance, under what circumstances would a healthcare professional be justified to disclose a patient's HIV/AIDS status to caregivers and third parties? What should a healthcare professional do, if a patient refuses to give informed consent to disclose his/her status to caregivers and third parties who are in danger of being exposed to serious risk? Furthermore, how should a physician ensure that consent obtained from a patient to make certain disclosure about personal information is not abused where the patient is treated by a team of healthcare professionals? Finally, it enquires into the test for determining what is in the interest of the public or public health as a condition for disclosing a patient's confidential information as contemplated by law.

*Medical Confidentiality and Professional Secrecy*

Confidentiality is an ethical principle particularly relevant in the provision of healthcare. The principle of confidentiality encompasses the view that a person should be entitled to privacy concerning his or her most personal and psychological secrets. It is also the basis for an effective relationship between the patient and the healthcare provider. Only if a person feels sure that the health care provider will keep confidential any information provided will he or she come forward and share information that may be critical to making decisions about effective clinical care and treatment. Thus healthcare professionals have long recognised and respected their duty and the need to protect the confidentiality of patients. As a result of this duty, healthcare professionals recognize that they should only disclose highly personal information, such as HIV status, with the informed consent of the patient.[5]

There are two conditions necessary to fulfil the ethical duty of confidentiality according to Gillon. The first condition is that one person, (a doctor), must undertake either explicitly or implicitly, not to disclose another's secrets, and that other person, (the patient), must disclose to the first person information what he considers to be secret. Hence, there cannot be a transgression of confidentiality if the information is not regarded as secret by the person giving it. Equally, it is only because doctors have

[5] 'Opening up the HIV and AIDS Pandemic; Guidance on encouraging beneficial disclosure, ethical partner counseling and appropriate use of HIV case reporting.' (UNAIDS/WHO) Geneva, Switzerland, November, 2000.<www.who.int/hiv> accessed 25/01/17

undertaken not to disclose patients' secrets, that they have acquired a duty of confidentiality.[6]

The concept of confidentiality has played a vital role in the public's perception that there is something sacred in the doctor-patient relationship. There are numerous codes of ethics which affirm the significance of confidentiality, such as the Declaration of Geneva, The World's Medical Association's International Code of Medical Ethics, and importantly, the Hippocratic Oath. The moral foundation of a doctor-patient relationship is grounded in confidentiality and trust. Any information that a patient gives a doctor belongs to him or her, and the doctor is duty bound to act as its guardian. If it is acknowledged that there is a moral obligation to respect the dignity and worth of a patient viz, respect for his or her autonomy, then it follows that any information given in trust to doctors should remain in trust.[8]

The professional autonomy of doctors would be threatened if they were required to disclose information derived from their relationship with their patients, as the information will move from the doctor-patient relationship to the public domain. If confidentiality is no longer respected, then there is the possibility that patients will not go for HIV testing, counselling and treatment, because they no longer trust their doctor. Furthermore, where confidentiality is not guaranteed, the quality of information provided by patients will be diluted as they may choose to divulge only information that they assume or know to be safe such that the information provided (or withheld) will impact on the doctor's clinical diagnosis. Hence, it is imperative to ensure respect for persons as it constitutes a very important reason to protect confidentiality.

In the absence of a specific contractual duty to keep a patient's confidence, the common law puts a doctor under a duty to respect the confidence of the patient. This is based on the fact that doctorpatient relationship is essentially characterized as one of a fiduciary nature. It has been suggested that the scope of the duty covers information received directly and extends to those received indirectly in so far as they are received in the doctor's character as the patient's doctor.[7] Thus while the duty surely covers information and observation of the patient, it extends to information received from third parties in circumstances where the third party gives the information knowing of the existence of the doctor-patient relationship. Once information is received in its character as the patient's doctor in his professional capacity, it is immaterial whether it was gotten from a professional colleague or from a non-doctor for both is indistinguishable as the duty of confidentiality applies to both.[10]

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[6] Bogaert D.k, et al, 'Human Immunodeficiency Virus: confidentiality and disclosure of information to third parties.' <www.tandfonline.org> accessed 25/01/17 [8] ibid

[7] Emiri. O.F., *Medical Law and Ethics in Nigeria* (Malthouse Law Books, 2012) p. 353 [10] Ibid

However, there have been diverse views on whether the duty will extend to cases where the third party is unaware of the doctorpatient relation and the issue remains unresolved. In *AG v Guardian Newspaper Ltd (No 2)*[8] the English Court of Appeal subscribed to the proposition that there is a public interest in the legal enforcement and protection of confidences received in circumstances of confidentiality. It can be argued that since a doctor receives information almost always in those circumstances, he ought to come under an obligation of confidence. Others have suggested that in the context of information from third parties, it must however be shown that the party knows of the doctor-patient relationship to raise obligation on the part of the doctor.[9] The patient trusts that information about his person will be kept secret unless he permits disclosure. It means in effect that confidentiality turns around how the patient perceives the trust held by the doctor. One view is that it is the circumstance in which the doctor receives the information and not the knowledge of the informant or his status that ought to determine whether a duty does exist or not. That point was implicitly recognised by Lord Goff when he stated:

> …a duty of confidence arises when confidential information comes to the knowledge of a person (the confidant) in circumstances where he has notice or is held to have agreed, that the information is confidential, with the effect that it would be just in all the circumstances that he should be protected from disclosing the information to others.[10]

The statement puts beyond doubt that the enquiry ought to turn not on the knowledge of the informant, but rather on the knowledge of the confidant. A better view will be that a duty is owed once the doctor is aware of the confidential nature of the information notwithstanding that the third party informant is unaware of his professional relationship with the patient. From the days of Hippocrates until the present, doctors, have bound themselves not to divulge professional secrets and as such, a doctor ought to keep silent as to anything he sees or hears while visiting or treating the sick which is improper to divulge. The basis for this was well summarized by Lord Riddel as follows:

A doctor being in fiduciary capacity must preserve his patients' confidence unless relieved from the obligation by some lawful excuse of legal compulsion, the patient's consent, the performance of a moral or social duty, or protection of the doctor's interest. A doctor shares with other citizens the duty to assist in the detection and arrest of a person who has committed a serious crime. Everyone recognizes the necessity and importance of medical confidence, but we must recognize also that the rules regarding them exist for the welfare of the community and not for the aggrandizement or

[8] (1988) 3 All ER, 545, (1990) 1 AC 109.

[9] Emiri O.F., Op. Cit. at 354

[10] Ibid

convenience of a particular class. We must recognize also that they must be modified to meet the inevitable changes that occur in the necessities of various generations.[11]

The researchers agree with the latter view that only knowledge by a third party of an existing doctor-patient relationship should result in liability on the part of the doctor in the event that a third party becomes aware of the patient's confidence and goes ahead to divulge same. Consequently, for a patient to succeed in an action for breach of confidence, such patient must show conclusively two things, namely (i) that the information in the circumstances given or received was meant to be treated as confidential (ii) that the obligation to keep the information confidential was breached by the doctor.

*Rights of Persons Living with HIV/AIDS to Medical Treatment*

As a result of the risks associated with contact to persons living with HIV and AIDS, many of them have been denied medical attention on account of their status as HIV/AIDS patients. This practice has become very notorious in many health institutions and people who visit hospitals for some other complaints are simply tested for HIV for the safety of medical personnel. The refusal to treat a patient because he or she tested positive to a HIV test or discriminating against such patient or subjecting such patient to compulsory test or testing without the patient's authority, consent or permission for HIV test are all legally, medically and ethically wrong.[12] Furthermore, where a person living with HIV/AIDS is denied treatment, it is tantamount to denying such a person the right to life which is a basic fundamental right. Hence, there can be no enjoyment of the right to life if the right to healthcare is denied. It becomes salient therefore that people living with HIV and AIDS should have equal access to medical attention and be treated adequately without refusal of treatment. The point has been well articulated by a learned author as follows:

> People with HIV/AIDS have the same rights to healthcare and respectful treatment as any other person. It is therefore unethical and also a breach of the Hippocratic Oath for any health provider to refuse to care for any person who is HIV-positive or who has AIDS, or to make the care of any person contingent on that person having an HIV test.[13] The appropriate response and attitude of health personnel is to regard persons living with HIV/AIDS as sick patients who are in need of medical attention and the current situation where persons living with HIV/AIDS are discriminated against whether directly or indirectly must be strongly disapproved. The gravity of the problem of persons living with HIV/AIDS was well

[11] Ibid.

[12] Dada J. A., *Legal Aspects of Medical Practice in Nigeria* (2nd Ed.) (University of Calabar Press, 2013) p. 242

[13] O. Oluduro in Dada J.A. Ibid at p 244

captured by Cohen and Wiseberg[14] 'that persons living with HIV/AIDS face double jeopardy: they face death and while they are fighting for their lives; they often face discrimination'. In the case of *Hinkel v Wood*[18], the

Plaintiff Mr. Hinkel, a man living with HIV and AIDS telephoned the Defendant who had been his dentist since 1986, to request treatment. The Plaintiff alleged that the Defendant refused to treat him apparently because he was living with AIDS. In an action by the Plaintiff for damages, it was held that Hinkel's complaint was justified and accordingly awarded compensation totalling $3,400 for humiliation and hurt feelings.

However, where there is discrimination which can be justified, a medical practitioner or a healthcare institution will not be held liable. In *Jerome v De Marco*[15], the complainant who had health care for AIDS complained of discrimination in the provision of dental services contrary to Sections 1 and 8 of the Ontario Human Rights Code. The complainant stated that he had a morning appointment but the dentist deferred treatment until the end of the day when he learnt the complainant had AIDS. The Commission held that even though the action constituted discrimination based on handicap, the postponement was justified because persons living with HIV/AIDS may require deeper and more thorough dental cleaning, and given the tight schedule of the dentist, treating the complainant at the agreed time would have caused significant delay in the treatment of other patients which would have amounted to undue hardship under Section 16(1) of the Code. Accordingly, the claim of the complainant failed. Consequently, it is instructive to note that the justification for discrimination cannot be predicated on the provision of Section 35 of the 1999 Constitution which while guaranteeing right to personal liberty, recognises the need for deprivation of personal liberty in case of persons suffering from infectious or contagious diseases on grounds of public interest because HIV/AIDS is not a contagious or infectious disease as contemplated b the Constitution.[16]

*The Duty of Health Care Professionals to Warn Care Givers and Third Parties*

The right of confidentiality usually causes a conflict of moral principles for professionals in respective disciplines. For those in the medical profession, there is usually a conflict between a duty of autonomy of the patient and duty to protect others, particularly the right to life of the third parties (who are in danger of contracting the disease). One dilemma often faced by professionals in regard to confidentiality involves the different but related roles of ethics, law and clinical practice. The challenge has

[14] Cohen R. et al "Double Jeopardy-Threat to life and Human Rights; Discrimination against Persons with AIDS": *Cambridge M.A Human Rights Internet*, 1990 p. 3 [18] British Colombia Council of Human Rights, (Unreported) 29 June, 1993.

[15] Ontario Human Rights Commission, (Unreported) 12 March 1992.

[16] Dada J.A. Op. Cit. at 247

always been making a choice between maintaining a client's confidence and violating it in order to protect a third party at risk or harm.

The main ethical dilemma around confidentiality concerns the assessment of whether more harm is achieved by breaching confidentiality or by respecting it regardless of the consequences. When the issue is placed in the context of rights, the right of the individual (patient) to confidentiality can be in conflict with the right of another to be protected from harm, for instance, persons at the risk of acquiring the HIV infection like spouses and care givers (third parties). Therefore, difficulties usually arise because the extent to which limitations to confidentiality can be exercised are often not clearly articulated. In the landmark California Supreme Court case of *Tarasoff v University of California*[21], the majority of judges took the view that certain information falls outside the purview of confidentiality. The case in question involved two University of California students-Prosenjit Poddar and Tatiana Tarasoff who were into a relationship for a short time, until Tatiana quickly lost interest when she began to notice Prosenjit's possessive behaviour patterns. This prompted her to take a summer trip to Brazil to avoid her possessive suitor. Soon after her departure, Prosenjit became very depressed and he began seeing a psychiatrist at the University hospital in 1969. During these sessions, Prosenjit confessed his intention to kill Tatiana when she returned to the country at the end of the summer. The psychiatrist treating him, Dr. Lawrence Moore, notified campus police officers and requested that they detain Prosenjit for civil commitment. The police took Prosenjit into custody, but later released him after he promised not to harm Tatiana. The Director of psychiatry at the hospital ordered that Prosenjit's file be destroyed and that no further attempt be made to have him committed. Prosenjit ended therapy and moved in with Tatiana's brother, very close to Tatiana's apartment. When she returned to the country in October, Prosenjit went to her apartment to talk with her, and when she refused, Prosenjit stabbed her to death with a kitchen knife. Tatiana' parents brought a suit against both the psychotherapist who had treated Prosenjit and the University of California for failing to warn Tatiana or her parents of the threat Prosenjit posed to their daughter. The case law established in the trial places the public well-being ahead of the privacy rights of individual clients

[21] 17 Cal.3d 425;551 P. 2d 334;1976

and the familiar duty to warn arose out of the ensuing trial in 1974. Confusion surrounding the first trial prompted many professional agencies to urge the court to rehear the case and the case was reheard in 1976. Justice Tobriner, in a majority decision held that "when a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such

danger."[17] The decision in the above case strongly asserts that irrespective of the duty to ensure confidentiality, the physician has a duty to protect others from harm.

This duty is predicated on what is known as the principle of beneficence.[18] Beneficence simply means an act one does with the intention of benefitting other people. It also refers to the moral obligation to act for the benefit of others. The principle of beneficence demands that the physician should protect and defend the rights of others, prevent harm from occurring to others, and remove conditions that will cause harm to others. The researchers hold the view that the general principle of beneficence also applies in HIV and AIDS cases where infected persons refuse to disclose their status and also refuse to engage in safe sex practices. Where that is to be the case, the physician has an obligation to warn spouses or partners of such persons as under such circumstances, the physician's duty to the public outweighs the principle of confidentiality.

Thus, it can be argued that the onus to breach confidentiality or not lies in the ability and judgment of the doctor. According to MacFarlane and Reid, there are two major considerations which they consider to be justifiable reasons for breaching a patient's confidence.[19] The first exception to the duty to confidentiality arises when a statute makes provisions requiring medical practitioners to disclose information concerning a patient. Some statutes provide statutory rights for certain individuals, or bodies to have access to confidential information. A common example is where a statute may require a medical practitioner to notify the officer of the local authority whenever he is made aware of, or suspects that a patient is suffering from one of the diseases in a list of notifiable diseases. The second exception to the duty of confidentiality according to Macfarlane and Reid arises where there is an overriding public duty to disclose information. [20]Doctors have a common law duty to disclose information to the public if failure to do so will expose the public to a serious risk of death or harm. For example, confidential information may be disclosed where there is a possible threat that the infected person may attempt to infect other members of the public. Through disclosure of the information, members of the public may be protected from the risk of death or harm, or the occurrence of any serious crime. On occasions like this, relevant medical authorities may disclose information concerning the health status of a patient to the required bodies, or individuals, who are entitled to the information.

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[17] Miller M.R., 'The Ethics of Confidentiality: Professional Duties and the Uncooperative HIV-infected Patient.' University of Kansas. <www.kuscholarworks.ku.edu> accessed 3/02/17

[18] Nnamani C., 'Professional Confidentiality and HIV: Duty to warn Third Parties and its Social Implications to Public Health in Nigeria' in Beauchamp T, et al, *Principles of Biomedical Ethics*, 5th Ed, (Oxford University press, 2001)p. 306

[19] MacFarlane PJM, Reid SQ., *Queensland Health Law Hand Book*, (Queensland Government Printing Office, 2003). P.139

[20] Bogaert D.k, et al Op. Cit. P. 2

A doctor may also be required by law, to make disclosure in which case, no breach of confidentiality would be said to occur, like instances where limited information to some outside agencies may be permissible for purposes of statistics, accounting, data processing or other legitimate information. Similarly, if a patient is treated by other doctors in the course of his treatment, it would be expected that doctors would exchange information about the patient for purposes connected with further treatment or research. In this case, however, a degree of caution and prudence must be observed and consent obtained.[21] A doctor may also reveal confidences and secrets if he is required to present them before a court or tribunal, say if he has to defend himself or others against accusation of wrongful conduct. There may be rare occasions when a doctor receives information about a dangerous patient that can endanger the lives of others. He would, in that circumstance be expected to use good professional judgment to determine if there exists a need to warn those in danger from the patient. If he concludes that there is a need for such warning, then he must act unhesitatingly to prevent injury or loss of life even if that would amount to a breach of confidentiality.

One way that this dilemma can be resolved without difficulty is where the patient has personally agreed to disclose his/her status to their partner or where the patient consents to such disclosure but feels that it is too difficult a situation. In such a situation, the physician may be of immense help to such patient by offering to see the partner and being available to help the individual to do the telling, or alternatively, to be the one to tell. In the circumstance, it is essential that good preparation is undertaken and a specialist support service be sought as back-up. An appropriate way to begin is to first attempt to discuss the situation calmly with the patient and to ascertain whether the patient understands that he/she is placing someone else at risk of contracting HIV if not disclosed. This present researchers hold the view that it is only when a patient remains uncooperative to entreaties that disclosure be made to others who are at risk of contracting the infection that a physician will be justified to divulge such information on grounds of public interest.

The issue of medical confidentiality especially in HIV testing and reporting is very important partly because unauthorized disclosure of an individual's sero status may lead to social contempt or disgrace, estrangement of family and friends, and the loss of employment, housing and insurance. Accordingly, the principle of privacy and confidentiality insists that whatever information generated or knowledge gained by a medical practitioner about a patient in the course of a medical relationship must be kept secret. Disclosure of such medical information should only be with the permission or consent of the patient, or when a duty imposes a duty of disclosure. This duty has always existed in

[21] Ibid.

medical relationships and it is contained in the Hippocratic Oath and also recognised in common law.[22]

In *Re inquiry into the Confidentiality of Health Records in Ontario*[23] the court held that members of the medical profession have a duty of confidentiality with respect to their patients. The principle is so strict that any unauthorised disclosure or dissemination of the medical condition of a patient is actionable and raises liability in damages. The duty to respect the confidentiality of information is both ethical and legal; therefore, where there is unauthorised disclosure of the HIV status of a patient, the person responsible for the publication or unauthorised disclosure will be liable. However, not every disclosure of a patient's status without consent is wrong. There are instances where disclosure without consent will be justifiable. The question now is where do we draw a line between patient confidentiality and the need to disclose? Should we insist on maintaining patient confidentiality where other persons, especially unsuspecting partners are at significant risk of infection? It is argued that disclosure may be justifiable because of the need to protect human life and prevent the transmission of diseases. The Royal Society of Canada while stressing the importance of respecting the confidentiality of HIV/AIDS-related information observed that:

> A strong ethical case can be made n support of a physician's breaking confidence with a seropositive person when such a person persistently refuses to stop endangering the health and life of a sexual partner, when the physician knows the person in danger, and when the physician is the only one with knowledge.

The above position is instructive and the researchers agree with the same in all respects. No justification remains for keeping confidential the status of a patient who deliberately and recklessly goes about infecting unsuspecting persons, knowingly with the virus. Such a patient should not only be cautioned but should be subjected to criminal prosecution to serve as a deterrent to others who are recalcitrant. The writers hold the view that instances of permissible disclosure should be targeted at persons who are more exposed to the danger of infection like spouses and those who are attending to persons living with HIV/AIDS referred to as caregivers. Another mind-boggling issue is whether the conduct of a patient who deliberately transmits the virus to unsuspecting persons ought to be made criminally reprehensible. At the moment, there is no specific legislation on the issue in Nigeria. However, in jurisdictions like the United States, there are penal statutes dealing with HIV transmission and endangerment. While penal legislation may not serve as an effective deterrent, it is nonetheless a mechanism to check deliberate dissemination. There is a need to amend our penal laws such as the

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[22] Dada J.A. Op. Cit. at 248

[23] (1979) 98 DLR (3d) 704 at 71424

Criminal Code, Penal Code and the Administration of Criminal Justice Act and its state counterparts, to align with international best practices.

In Canada, there are legislation which permit physicians to report cases of AIDS, and sometimes cases of AIDS infection either nominally or non-nominally to medical health officers. There is also some legislation in some Canadian jurisdictions requiring or authorising disclosure by a physician of a patient's information if such disclosure is necessary to protect a third party, such as a spouse or care giver. Another instance where disclosure without consent may be justified is where there is a "duty to warn" or "duty to protect" others with a view to saving life, however, such a duty applies only to identified or readily identifiable persons. The courts in the United States have consistently held that a physician's duty of non-disclosure is outweighed in certain circumstances by the need for public safety and thus permissible disclosure can therefore be made with a view to stopping the spread of the virus, thereby saving lives in recognised instances.[24] The writers share the above view and propose that relevant authorities in Nigeria concerned with law-making should give due consideration to amending relevant laws to bridge the existing lacuna to conform to global best practices.

*Conclusion*

This work has unravelled the dilemma faced by healthcare professionals in the treatment of persons living with HIV and AIDS and has shown that these dilemmas are not easily resolved. The guiding principle seems to be hinged on the professional judgment of the physician or healthcare practitioner. It appears that the decision as to whether the status of an HIV and AIDS patient should be disclosed to third parties, (especially spouses and family members), on grounds of public health and safety is left to the discretion of the physician and as a result, most physicians act with caution and would rather prefer to maintain their patient's confidence due to the fiduciary relationship which suggests that their duty is first to the patient. Many healthcare professionals are afraid to act otherwise as a result of the existing fiduciary relationship and would prefer to err on the side of caution rather than defy the norm and go ahead to warn third parties in the event of risk or harm. The position ought to be that the duty of a physician or health care professional is not limited to his patient, but that such duty extends to third parties and society, particularly when public safety or interest is concerned.

A more serious concern is the dilemma faced by healthcare professionals in discharging their duties daily as a result of the conflict of interest resulting from the treatment of HIV and AIDS patients, whether it is proper to breach the confidence of a patient in a bid to protect third parties who are likely to be at risk if such disclosure is not made. On the whole, the need for a healthy doctor-patient relationship is critical as it creates the

[24] Dada J. A. Loc. Cit.

platform upon which adequate care and treatment can be administered to patients. Without this in place, it will be difficult, if not impossible for the physician to comprehend fully, diagnose and treat the patient properly. This view is held by the researchers as one of the greatest challenges confronting the fight against the spread of the disease.

In light of the foregoing, the following recommendations are therefore proffered:

1. Persons living with HIV and AIDS should be encouraged to carry out beneficial disclosures. This is disclosure that is voluntary and which respects the autonomy and dignity of the affected individuals. This will not only maintain ethical principles but will also serve as a direct public health function because it encourages people to access HIV prevention and care services.
2. The right of HIV and AIDS patients to confidentiality should be interpreted with due consideration and regard to the rights of health workers (caregivers) and family members who are likely to be at risk in the event of non-disclosure.
3. There should be comprehensive training of healthcare providers on HIV and AIDS and respect for human rights.
4. The deliberate spread of HIV by patients who refuse, against medical advice to adopt safe sex practices and to disclose their status to their partners should be treated as criminal conduct attracting penal sanctions.