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HIV/AIDS and Public Health Law

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HIV/AIDS AND PUBLIC HEALTH LAW

Mary Anne Bobinski*

I. INTRODUCTION

The Human Immunodeficiency Virus (“HIV”) was first recognized in the early 1980s as reports of unusual infections and immune system suppression in some gay men began to appear in medical journals and in public health reports.¹ The struggle to find the causes and methods of treating these conditions is nearly three decades old, yet each phase of society’s effort to grapple with this relatively new disease still resonates with lessons learned and unlearned. This chapter highlights the ways in which HIV infection has focused attention on the close relationship between public health practice and the legal system. The chapter begins with a brief summary of the medical aspects of HIV infection, the current data on the scope of infection in Canada and around the world, and an overview of the key public health law debates sparked by HIV. The remaining sections of the chapter will focus on the legal aspects of two major types of public health policies and objectives: case identification and the prevention of transmission.

* The author is grateful to Holly Harlow, Rachael Manion and Brenda Osmond for research assistance. The author also wishes to recognize the excellent resources on the legal and policy aspects of HIV/AIDS developed by the Canadian HIV/AIDS Legal Network, online: <<http://www.aidslaw.ca>>; these resources provide an in-depth analysis of many of the issues summarized in this chapter. This chapter largely focuses on the public health implication of HIV/AIDS in common law Canada.

¹ See for example U.S. Centers for Disease Control and Prevention, “A Cluster of Kaposi’s Sarcoma and Pneumocystis carinii Pneumonia among Homosexual Male Residents of Los Angeles and Orange Counties, California” (18 June 1982) 31 MMWR 305.

II. MEDICAL ASPECTS OF HIV/AIDS

(a) Understanding HIV/AIDS

HIV is a retrovirus transmitted when virus-laden body fluids or tissues from an infected person come into contact with a portal of entry (such as an open wound or mucosal membrane) of another individual.² The major routes of transmission over the history of the disease have included: blood transfusions or tissue transplants, sexual activity such as vaginal or anal intercourse, perinatal transmission through childbirth or breastfeeding, transmission through sharing needles used for injections, and accidental exposures to blood or other infected body fluids in occupational settings.³ The probability of transmission depends on a number of factors including the type of exposure and the concentration of viral particles.⁴ Once transmission occurs, the virus can be found in a wide range of different body tissues although it creates a home base or reservoir of infected cells in lymphatic tissue.⁵ The virus preferentially infects CD4 T-lymphocytes, key actors in the body's immune system.⁶

Untreated HIV infection follows a relatively long course that can last a decade or more. During the acute phase, the virus invades host cells and causes those cells to assist in the creation and dissemination of new viral particles. Two to three weeks after infection, many individuals experience a transitory fever, swollen lymph glands, a rash and other mild symptoms; these might be the only outward manifestation of HIV infection for many years.⁷ The infected person creates antibodies in response to the virus but the immune response is not effective in clearing

² A retrovirus is one which uses RNA to encode its basic genetic instructions rather than DNA. Researchers have made great progress in understanding the process of infection at the cellular level. See generally Warner C. Greene & B. Matija Peterlin, "Molecular Insights into HIV Biology" (February 2006) in Laurence Peiperl, Susa Coffey, Oliver Bacon & Paul Volberding, eds., *HIV InSite Knowledge Base* (online textbook from the UCSF Center for HIV Information), online: <<http://hivinsite.ucsf.edu/InSite?page=kb-00&doc=kb-02-01-01>>. The HIV InSite Knowledge Base offers medical reference material about HIV infection in an online format which allows for updates to incorporate recent research results.

³ Health Canada, "HIV and AIDS in Canada: Surveillance Report to December 31, 2003" (April 2004) at 66-67, online: Public Health Agency of Canada <<http://www.phac-aspc.gc.ca/publicat/aids-sida/haic-vsac1203/pdf/haic-vsac1203.pdf>>. See also C. Bradley Hare, "Clinical Overview of HIV Disease" (January 2006) in Laurence Peiperl, Susa Coffey, Oliver Bacon & Paul Volberding, eds., *HIV InSite Knowledge Base*, online: <<http://hivinsite.ucsf.edu/InSite?page=kb-00&doc=kb-02-01-01>>.

⁴ See, e.g., Melissa Pope & Ashley T. Hasse, "Transmission, acute HIV-1 infection and the quest for strategies to prevent infection" (2003) 9 *Nat. Med.* 847.

⁵ *Ibid.*, at 847.

⁶ Mario Stevenson, "HIV-1 pathogenesis" (2003) 9 *Nat. Med.* 853 at 853.

⁷ Melissa Pope & Ashley T. Hasse, "Transmission, acute HIV-1 infection and the quest for strategies to prevent infection" (2003) 9 *Nat. Med.* 847.

the viral infection.⁸ The window between infection and the creation of detectable antibodies (a process called seroconversion) can be three or more months. A person is capable of transmitting the virus to others during this window period but may nonetheless test negative in standard antibody tests used to determine exposure to HIV.

The infection then enters what has been misnamed the latent phase or latency period. While it is true that the infected individual may not exhibit clear signs and symptoms of infection, the virus itself remains very active. Researchers have demonstrated that the virus continues to interact with the immune system, eventually destroying it.⁹ The demise of the immune system is then associated with advanced HIV infection. The patients who first came to the attention of public health officials in the early 1980s had advanced HIV infection; they had suppressed immune systems and a wide range of opportunistic infections.¹⁰ This constellation of symptoms was given the name “Acquired Immunodeficiency Syndrome (AIDS)” even before the viral cause was identified in 1983 and long before the first tests for HIV antibodies became available in 1985.¹¹

The distinction between HIV infection and a diagnosis of AIDS might be thought of as meaningless in some respects and misleading in others. It is meaningless because an individual can transmit the virus to others throughout the course of infection, whether or not there has been an AIDS diagnosis. It is misleading because AIDS statistics necessarily underestimate the true incidence and prevalence of HIV infection. The distinction nonetheless has retained its vitality, in part because of history and the clinical significance of an AIDS diagnosis. The distinction also

⁸ Norman L. Letvin & Bruce D. Walker, “Immunopathogenesis and immunotherapy in AIDS virus infections (2003) 9 Nat. Med. 861.

⁹ *Ibid.*

¹⁰ An “opportunistic infection” is one which is more frequently observed in individuals with depressed immune function and which is more rarely observed in persons with healthy immune systems; it can also be called an “indicator disease”.

¹¹ U.S. CDC, U.S. Dep’t Health and Human Services, “CDC Guidelines for National Human Immunodeficiency Virus Case Surveillance, Including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome” (10 December 1999) 48 MMWR Recomm Rep. (RR13) 1 (detailing most recent surveillance guidelines and summarizing historical changes in diagnostic criteria). The case definition for “AIDS” in the United States is slightly broader than the case definition used across Canada and many other countries because it includes persons with HIV infection and evidence of depressed immune function (CD4 T-lymphocyte counts of less than 200 cells per microliter) who may not yet have experienced an “indicator” disease. Compare Canadian AIDS Society (CAS) and Health Canada, “A Guide to HIV/AIDS Epidemiological and Surveillance Terms” (2002) 10-11, online: Public Health Agency of Canada <http://www.phac-aspc.gc.ca/publicat/haest-tesvs/pdf/hiv_glossary_e.pdf> with U.S. CDC, “1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults” (18 December 1992) 41 MMWR Recomm Rep. (RR17) 1.

reflects practical differences in the ability to gather data about HIV infection as opposed to AIDS diagnoses. Individuals with the symptoms necessary for an AIDS diagnosis are quite sick; they are more likely to come to the attention of health care professionals and to be correctly diagnosed than individuals with asymptomatic HIV infection. This was certainly true in the early years of the pandemic, before the introduction of medical tests indicative of HIV infection, and remains true today to the extent that HIV surveillance data depends on voluntary HIV testing.

(b) HIV Testing

The early HIV-related tests searched for antibodies to the HIV virus in blood samples and results took weeks to obtain.¹² Rapid HIV antibody tests can yield results from blood samples within minutes.¹³ Other new tests look for antibodies in saliva and urine.¹⁴ Tests that probe directly for HIV rather than for antibodies can be used to identify cases of infection before an individual has developed antibodies; public health officials are exploring cost-effective and efficient methods of using these tests to reduce the risk of “false negative” results for persons tested during the “window period”.¹⁵

Once an individual has been diagnosed with HIV infection, health care providers and researchers rely on more elaborate tests to make clinical assessments about the stage of infection and the effectiveness of therapy. One testing methodology measures viral load, or the amount of HIV virus found in a sample.¹⁶ Another focuses on the level of CD4 T-lymphocytes as a measure of the status of the infected person’s immune system.¹⁷ The most recently developed tests attempt to measure the drug

¹² C. Bradley Hare, “Clinical Overview of HIV Disease” in Laurence Peiperl, Susa Coffey, Oliver Bacon & Paul Volberding eds., *HIV InSite Knowledge Base*, online: <<http://hivinsite.ucsf.edu/InSite?page=kb-00&doc=kb-02-01-01>>.

¹³ *Ibid.* See also, Canadian HIV/AIDS Legal Network, “Rapid HIV testing” in *HIV Testing* (2007) (series of 12 information sheets on HIV testing in Canada), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=713>>; Public Health Agency of Canada, “Point-of-Care HIV Testing Using Rapid HIV Test Kits: Guidance for Health-Care Professionals” (2007) 33:S2 CCDR 1, online: <<http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/07pdf/33s2-eng.pdf>>.

¹⁴ C. Bradley Hare, “Clinical Overview of HIV Disease” in Laurence Peiperl, Susa Coffey, Oliver Bacon & Paul Volberding, eds., *HIV InSite Knowledge Base*, online: <<http://hivinsite.ucsf.edu/InSite?page=kb-00&doc=kb-02-01-01>>.

¹⁵ Public Health Agency of Canada, “HIV Testing and Counselling: Policies in Transition?” (2007) (research paper prepared for the International Public Health Dialogue on HIV Testing and Counseling, Toronto, 17 August 2006), online: <<http://www.phac-aspc.gc.ca/aids-sida/publication/hivtest/index-eng.php>>.

¹⁶ *Ibid.*

¹⁷ *Ibid.*

resistance of the viral strains infecting a particular individual; these tests can improve medication management for the individual and are also an important source of data on the overall rates of viral resistance to particular antiretroviral therapies.¹⁸

(c) Treatment for HIV Infection and Associated Illnesses

The early years of the HIV pandemic were characterized by the complete absence of treatments directly addressing the infection itself. Treatment instead focused on combatting the opportunistic infections which caused morbidity and mortality for persons with advanced HIV infection.¹⁹ The first drug to directly combat HIV replication in infected individuals was introduced in 1987.²⁰ This drug, and the few other single-agent drug therapies developed during the early 1990s, were an important but incomplete advance. These “monotherapies” had significant side effects and their effectiveness was rapidly diminished by the emergence of drug-resistant viral strains. Researchers continued to develop new drugs designed to target different parts of the virus’s life cycle.²¹

Researchers also discovered that the antiretroviral drugs could be used to reduce the risk of HIV transmission from a woman to her child during pregnancy and birth. The North American rate of perinatal transmission is approximately 25-30 per cent without treatment.²² The risk of HIV transmission can be reduced to single digit percentages if the pregnant woman takes even a short course of antiretroviral therapy.²³ Antiretroviral therapy can also be used to reduce the risk of HIV transmission arising from other types of exposure incidents.

By 1995, researchers began to recommend combination drug therapies to patients. This approach, often called highly active

¹⁸ *Ibid.* Specialized tests may also be able to link cases of HIV infection by studying the genetic variation of the virus; however, linking cases does not demonstrate the direction of transmission. See, e.g., Gary Blick *et al.*, “The Probable Source of Both the Primary Multidrug-Resistant (MDR) HIV-1 Strain Found in a Patient with Rapid Progression to AIDS and a Second Recombinant MDR Strain Found in a Chronically HIV-1–Infected Patient” (2007) 195 *J. Infect. Dis.* 1250.

¹⁹ Public Health Agency of Canada, “HIV Testing and Counselling: Policies in Transition?” (2007) (research paper prepared for the International Public Health Dialogue on HIV Testing and Counseling, Toronto, 17 August 2006), online: <<http://www.phac-aspc.gc.ca/aids-sida/publication/hivtest/index-eng.php>>. See also Roger J. Pomerantz & David L. Horn, “Twenty years of therapy for HIV-1 infection” (July 2003) 9 *Nat. Med.* 867.

²⁰ Pomerantz & Horn, *ibid.* (zidovudine or AZT).

²¹ *Ibid.*, at 868.

²² Ronald O. Valdiserri, Lydia L. Ogden & Eugene McCray, “Accomplishments in HIV prevention science: implications for stemming the epidemic” (July 2003) 9 *Nat. Med.* 881 at 884.

²³ *Ibid.*

antiretroviral therapy (“HAART”) was very effective in reducing viral load and mortality rates in many persons with HIV infection.²⁴ The new therapeutic regime still could not eliminate the viral infection, but researchers, care providers and the public began to contemplate a future in which HIV infection might be considered to be a serious chronic illness rather than an inevitably fatal condition. This enthusiasm soon was tempered by many factors including the continued development of drug resistant strains of HIV, the severe and debilitating drug side effects experienced by many patients, and the significant social, practical and economic barriers to successfully accessing and maintaining adherence to this complex and expensive form of care.²⁵

(d) HIV/AIDS Statistics and Special Populations

HIV is now a global pandemic.²⁶ According to the Joint United Nations Programme on HIV/AIDS (“UNAIDS”), “an estimated 33.2 million people (range 30.6–36.1 million) were living with HIV in 2007”.²⁷ Global HIV prevalence rates have remained level since 2001; however, the numbers of people living with HIV have continued to rise, due to population growth and the life-prolonging effects of antiretroviral therapy.²⁸ The prevalence and incidence of HIV infection varies from country to country and, often, from population group to population group within a particular geographic region.²⁹ Sub-Saharan Africa has the highest levels of HIV infection globally: “[m]ore than two thirds (68%) of all people HIV-positive live in this region where more than three quarters (76%) of all AIDS deaths in 2007 occurred”; the disease is the leading cause of death in that region.³⁰ While HIV prevalence has been declining

²⁴ Roger J. Pomerantz & David L. Horn, “Twenty years of therapy for HIV-1 infection” (July 2003) 9 *Nat. Med.* 867 at 868.

²⁵ *Ibid.*, at 869-72.

²⁶ A “pandemic” is a disease that is widespread across many countries or around the world; an “epidemic” can occur in a narrower geographic location. See Oxford English Dictionary, s.v. “pandemic” and “epidemic”, online: <<http://dictionary.oed.com>>.

²⁷ UNAIDS, “AIDS Epidemic Update: December 2007” at 1, online: <http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf>.

²⁸ *Ibid.*, at 4.

²⁹ “Incidence is the number of *new* events of a specific disease during a specified period of time in a specified population.” Canadian AIDS Society (CAS) and Health Canada, “A Guide to HIV/AIDS Epidemiology and Surveillance Terms” (2002) at 31 (emphasis in original), online: Public Health Agency of Canada <http://www.phac-aspc.gc.ca/publicat/haest-tesvs/pdf/hiv_glossary_e.pdf>. “Prevalence is the total number of people with a specific disease or health condition living in a defined population at a particular time.” It is often useful to express incidence or prevalence as a “rate” or as a proportion of the total population at risk for the condition (*ibid.*, at 39).

³⁰ UNAIDS, “AIDS Epidemic Update: December 2007”, online: <http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf> at 4, 15.

or leveling off in some regions in Africa, HIV prevalence in southern Africa remains high, with eight countries in that region registering adult HIV prevalence rates over 15 per cent.³¹ Outside Sub-Saharan Africa, the HIV epidemic is “primarily concentrated among populations most at risk, such as men who have sex with men, injecting drug users, sex workers, and their sexual partners”.³²

The major routes of transmission have varied from region to region and over time. This has had a significant impact on the populations affected by the disease. For example, despite the early association in North America between HIV transmission and unprotected sexual activities between males, over half of all people living with HIV worldwide are women.³³ Young people are also disproportionately affected, accounting for 40 per cent of all new HIV infections world wide.³⁴

Although gaps and errors in reporting make it difficult to know the precise date for HIV/AIDS prevalence and incidence in any society, the statistics for HIV/AIDS in Canada make clear that the prevalence of infection is significant and that it is not uniformly spread throughout society. As of December 31, 2006, over 20,000 cases of AIDS had been diagnosed in Canada since the beginning of the epidemic; there were more than 13,000 reported deaths during this same time period.³⁵ The incidence and prevalence of HIV infection is even more difficult to determine because of variability in the rates of testing, the degree of reporting, and the rates of risky behaviour or activities. Within these constraints, public health researchers have produced reasonable estimates:

The Public Health Agency of Canada (PHAC) produced estimates of HIV prevalence to the end of 2005 and HIV incidence in 2005 ... It was estimated that at the end of 2005 there were approximately 58,000 ... people in Canada living with HIV (including those living with AIDS), of whom approximately 27% were undiagnosed. The number of people in Canada newly infected with HIV in 2005 was estimated to be 2,300-4,500.³⁶

³¹ *Ibid.*, at 15.

³² *Ibid.*, at 4.

³³ *Ibid.*, at 8.

³⁴ *Ibid.*, at 21.

³⁵ Health Canada, “HIV and AIDS in Canada: Surveillance Report to December 31, 2006” (2007) at 7 and 59 (due to reporting delays, omissions and errors, these figures cannot be compared to deduce the number of individuals currently living with an AIDS diagnosis in Canada), online: Public Health Agency of Canada <<http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/pdf/survrep1206.pdf>>.

³⁶ *Ibid.*, at 1 (reference omitted). Note that this figure represents the number of persons *living* with HIV infection, not the number of Canadians who have acquired HIV infection since the beginning of the epidemic. Incidence and prevalence rates are subject to error.

The number of HIV diagnoses declined from 1996 to 2000, increased in 2001, and then remained stable at about 2,500 new diagnoses per year beginning in 2002.³⁷

Researchers organize data in “exposure categories” according to the likely mode of transmission. There have been significant changes in the routes of HIV transmission for new infections over time. Sexual activity between men accounted for over 60 per cent of the cases of HIV infection reported from 1985–2000 but accounted for less than 40 per cent of the new infections reported in 2006.³⁸ Exposure to HIV through intravenous drug use (“IDU”) also has varied over time, rising to over 28 per cent in 1998–1999 before beginning to drop.³⁹ This exposure category still accounted for nearly 20 per cent of the newly reported infections in 2006.⁴⁰ Meanwhile, the percentage of cases associated with heterosexual contact has increased from about 12 per cent in 1985–2000 to just over 30 per cent in 2006.⁴¹

The same Canadian data can also be analyzed using gender and ethnic categories. The percentage of new HIV infection reports in adult women has more than doubled since the early years of the epidemic, rising from about 11 per cent of the positive test results recorded from 1985–1996 to approximately 28 per cent of the positive test results in 2006.⁴² HIV infection data cannot currently be used to track ethnicity because of inconsistent reporting across provinces. Ethnicity data is available for reported AIDS cases and shows significant ethnic variations.⁴³ About 11 per cent of AIDS diagnoses in 2006 were recorded

Researchers reported in 2008 that HIV incidence rates in the United States were 40 per cent higher than had been thought. Lawrence K. Altman, “HIV Study Finds Rate 40% Higher Than Estimated” *The New York Times* (3 August 2008).

³⁷ Health Canada, “HIV and AIDS in Canada: Surveillance Report to December 31, 2006” (2007) at 2 (Figure 1), online: Public Health Agency of Canada <<http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/pdf/survrep1206.pdf>>.

³⁸ *Ibid.*, at 17 (Table 5A). There is a separate exposure category for men who have sex with men and who are also involved in injection drug use. Only a small (and relatively constant) percentage of HIV test reports are found in this combined exposure group (*ibid.*).

³⁹ Health Canada, “HIV and AIDS in Canada: Surveillance Report to December 31, 2006” (2007), online: Public Health Agency of Canada <<http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/pdf/survrep1206.pdf>> at 17 (Table 5A); and Health Canada, “HIV and AIDS in Canada: Surveillance Report to December 31, 2003” (April 2004) at 16 (Table 5A), online: Public Health Agency of Canada <<http://www.phac-aspc.gc.ca/publicat/aids-sida/haic-vsac1203/pdf/haic-vsac1203.pdf>>.

⁴⁰ Health Canada, “HIV and AIDS in Canada: Surveillance Report to December 31, 2006” (2007), online: Public Health Agency of Canada <<http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/pdf/survrep1206.pdf>> at 17 (Table 5A).

⁴¹ *Ibid.*

⁴² *Ibid.*, at 13 (Table 3).

⁴³ *Ibid.*, at 56 (Table 20). Ethnicity data is not available for AIDS cases in Ontario beginning in 2005.

in Black Canadians.⁴⁴ The percentage of AIDS cases diagnosed in Aboriginal Canadians moved from low single digits in the period from 1979–2000 to nearly 25 per cent of diagnoses reported in 2006.⁴⁵ These increases are cause for significant concern as they might reflect changes in the distribution of risky behaviours and/or differences in access to medical treatments that slow or prevent the movement from HIV infection to an AIDS diagnosis.

(e) HIV/AIDS and Public Health

The medical aspects of HIV lead inexorably into a range of issues for public health officials, judges and politicians. Confronted with an apparently new life-threatening disease, members of each of these groups have struggled to establish policies that would protect the public's health while also protecting the individual liberty, lives and dignity of those infected with the virus. Several characteristics of HIV have arguably driven the public policy debate. Unlike other serious illnesses such as smallpox or pandemic influenza, HIV is relatively difficult to transmit. The routes of transmission involve exposure to blood or body fluids through typically voluntary activities. The activities associated with transmission — sex, needle-sharing and childbearing — are value-laden and sometimes controversial. Persons infected with the virus can live for decades in relatively good health, able to participate in employment and their communities without posing any threat to public health.

Public health policies seek to match the threat of disease with the required response.⁴⁶ HIV presented a new challenge when it emerged in the 1980s. While similar to other sexually transmitted diseases in its mode of transmission and its association with socially stigmatized behaviours, it was decidedly dissimilar in the severity of the consequences and the absence of effective treatments. While similar to other life threatening diseases such as tuberculosis (TB) or smallpox, it was quite dissimilar in its degree of infectiousness, its mode of transmission, the absence of a vaccine, and the length of time during which infected and contagious

⁴⁴ *Ibid.* By comparison, only 2.5 per cent of Canadians identified themselves as Black in the 2006 Census: “2006 Census: Ethnic origin, visible minorities, place of work and mode of transportation”, online: Statistics Canada <<http://www.statcan.ca/Daily/English/080402/d080402a.htm>>.

⁴⁵ Health Canada, “HIV and AIDS in Canada: Surveillance Report to December 31, 2006” (2007), online: Public Health Agency of Canada <<http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/pdf/survrep1206.pdf>> at 56 (Table 20).

⁴⁶ See generally Lawrence O. Gostin, *Public Health Law: Power, Duty, Restraint* (Berkeley: University of California Press, 2008); Lawrence O. Gostin, Scott Burris & Zita Lazzarini, “The Law and the Public's Health: A Study of Infectious Disease Law in the United States” (1999) 99 Colum. L. Rev. 59.

persons remained capable of contributing to society. How should society respond to this new disease? The emergence of HIV infection prompted policy makers to begin to re-examine long-neglected aspects of public health policy and law.

The ensuing debates focused on three broad areas: (1) the proper locus of public health authority and responsibility; (2) the extent to which HIV-specific policies or laws were warranted; and (3) the balance between the exercise of public health authority and the protection of individual liberty.

The first issue is a familiar one for societies, like Canada, operating within a federal form of government. The Constitution of 1867 gives health-related responsibilities to both the federal government and the provinces. Provinces have the primary authority and responsibility for the protection of local public health.⁴⁷ Provinces also maintain jurisdiction over “Property and Civil Rights in the Province”, including common law claims arising in torts and contracts.⁴⁸ The federal government has direct jurisdiction over preventing the transmission of disease over international borders.⁴⁹ The federal government also controls criminal law, trade and commerce, and retains the authority “to make Laws for the Peace, Order, and good Government of Canada in relation to all Matters not coming within the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces”.⁵⁰ The end result is a complex web of interlocking responsibilities for the management of the challenges posed by HIV.

Based in part on studies of Canada’s response to emerging infectious diseases such as SARS, Canada established a new federal Public Health Agency with a newly created position for a Chief Public Health Officer in 2006.⁵¹ The legislation suggests that the federal government hopes to take more affirmative steps to promote public health while recognizing and

⁴⁷ *Constitution Act, 1867* (U.K.), 30 & 31 Vict., c. 3, s. 92(7), reprinted in R.S.C. 1985, App. II, No. 5.

⁴⁸ *Ibid.*, s. 92(13). See also National Advisory Committee on SARS and Public Health, “Learning from SARS: Renewal of Public Health in Canada” (October 2003) at 166, online: <<http://www.phac-aspc.gc.ca/publicat/sars-sras/pdf/sars-e.pdf>>.

⁴⁹ *Constitution Act, 1867* (U.K.), 30 & 31 Vict., c. 3, s. 92(7), reprinted in R.S.C. 1985, App. II, No. 5. See also National Advisory Committee on SARS and Public Health (*ibid.*, at 166).

⁵⁰ *Constitution Act, 1867, ibid.*, s. 91(2) (criminal law power); s. 91(27) (trade and commerce); s. 91 preamble (Peace, Order and good Government).

⁵¹ *Public Health Agency of Canada Act, 2006*, S.C. 2006, c. 5.

respecting jurisdictional complexities.⁵² The implications of this reorganization for Canada's response to HIV are not yet clear.

The second major debate focuses on "HIV exceptionalism": whether HIV infection presents unique characteristics that require an individualized legal or social response or whether it would be more appropriate to rely on general principles applicable to a wide range of other diseases or health conditions.⁵³ Advocates for people with HIV infection or for communities considered to be at risk for infection noted the special problems of fear and discrimination surrounding HIV and sometimes argued for specific new legal protections. Critics of exceptionalism argued that HIV should be treated like any other potentially fatal transmissible condition. These critics of special policies for HIV-infection contended that the emphasis on the rights of persons with HIV-infection prevented the implementation of traditional public health strategies, such as testing, reporting and contact tracing.

At a more general level, the debate about "exceptionalism" grew out of concerns about the capacity of the public health and legal systems to respond to a wide range of diseases or conditions. Policy-makers in countries around the world reacted to the unique problems presented by HIV infection with a host of tailored policies and laws governing discrete areas of concern ranging from the use of HIV-antibody testing to the creation of specific criminal offences related to the intentional or reckless transmission of HIV.⁵⁴ Critics of this approach argued that the existing

⁵² The Preamble establishes five major goals for the federal government: (1) "to take public health measures, including measures relating to health protection and promotion, population health assessment, health surveillance, disease and injury prevention, and public health emergency preparedness and response"; (2) "to foster collaboration within the field of public health and to coordinate federal policies and programs in the area of public health"; (3) "to promote cooperation and consultation in the field of public health with provincial and territorial governments"; (4) "to foster cooperation in that field with foreign governments and international organizations, as well as other interested persons or organizations"; and (5) to "contribute to federal efforts to identify and reduce public health risk factors and to support national readiness for public health threats" (*ibid.*). See also Amir Attaran & Kumanan Wilson, "A Legal and Epidemiological Justification for Federal Authority in Public Health Emergencies" (2007) McGill L.J. 381 (advocating expansion of federal legislation regarding epidemics); Kumanan Wilson & Christopher MacLennan, "Federalism and Public Health Law in Canada: Opportunities and Unanswered Questions" (2005) 14:2 Health L. Rev. 3.

⁵³ Ronald Bayer & Amy L. Fairchild, "Changing the Paradigm for HIV Testing — The End of Exceptionalism" (2006) 355 N. Eng. J. Med. 647; Ronald Bayer, "Public health policy and the AIDS epidemic: An end to HIV exceptionalism?" (1991) 324 N. Eng. J. Med. 1500.

⁵⁴ The trend toward HIV-specific legislation was particularly pronounced in the United States. See for example, "State Statutes Dealing with HIV and AIDS: A Comprehensive State-by-State Summary" (2004 Edition) 13 Law & Sexuality 1. For a summary of HIV-related statutes in the United States see also online: <http://www.law.tulane.edu/tlsjournals/tlas/aids_statutes.aspx>.

framework of public health laws and policies should not be abandoned in response to new threats like HIV but that the system should be adjusted to take into account the lessons learned from the encounter. Thus, the proper response to fears about the disclosure of HIV-related information would be to re-examine the adequacy of confidentiality protections generally rather than enacting a completely new law to protect HIV-related information.

The third major debate involves the balance between protection of the public and protection of the individual. A public health policy strictly focused on risk identification and elimination theoretically could include highly intrusive measures, such as mandatory testing, treatment or quarantine, designed to identify and to reduce the risk of transmission. At the other extreme, rigid protection of individual liberties could render public health authorities powerless to address real risks posed by individuals with highly contagious and dangerous diseases. The correct path clearly lies somewhere between these two extremes, and the debates surrounding HIV infection provided an important opportunity to consciously chart a new course. The result was a new conceptualization of public health and individual liberty that values both as essential to a safe society. The protection of individual liberty began to be viewed as an important public health tool rather than as a conflicting obligation.⁵⁵ Protection of individual liberties might encourage persons at risk for HIV infection to present themselves for HIV testing and counseling, for example.

The remaining sections of this chapter will explore how Canada's public health and legal systems have responded to the problems presented by HIV. This chapter will focus on two categories of public health interventions: (1) identifying cases of infection through HIV testing and reporting; and (2) using law to reduce the risk of transmission. The chapter will conclude with a brief discussion of the implications of HIV-related policies for the future.

III. CASE IDENTIFICATION: HIV TESTING AND CONFIDENTIALITY

(a) Overview

Gathering information about a possible health threat is an important precondition to mounting an effective response. Authorities need to know that an illness is present in a population to effectively manage public

⁵⁵ See generally Lawrence O. Gostin, Scott Burris & Zita Lazzarini, "The Law and the Public's Health: A Study of Infectious Disease Law in the United States" (1999) 99 Colum. L. Rev. 59.

health policies. Health care providers must know a person is infected to properly direct that person's health care. Individuals also have an interest in knowing their own health status in order to seek proper treatment and to ensure the safety of others. Although every member of society should take steps to reduce risky activities, individuals who discover they are infected with HIV have a particularly powerful basis for changing their behaviour to reduce the risk of transmission to others.⁵⁶ These issues are particularly important for HIV infection, given the dramatic consequences of infection.

The introduction of HIV antibody tests in 1985 presented an opportunity to gather information about the incidence and prevalence of HIV infection and to use that information for the benefit of the individual and society. Two key questions must be answered about HIV testing programs: (1) Under what circumstances can the tests be administered?; and (2) What use can be made of the results? Section III (b) will focus on the implementation of HIV testing. Section III (c) will explore the implications of privacy and confidentiality for the use of test results and then will relate the debate to the specific issue of HIV/AIDS reporting rules.

(b) HIV Testing

One key issue for HIV testing programs involves the degree of voluntariness associated with the testing program.⁵⁷ "Mandatory" testing programs are those in which the testing is imposed whether or not the person to be tested consents. "Conditional" testing programs are those associated with participation in a voluntary activity (such as donating

⁵⁶ Public Health Agency of Canada, "HIV Testing and Counselling: Policies in Transition?" (2007) (research paper prepared for the International Public Health Dialogue on HIV Testing and Counseling, Toronto, 17 August 2006), online: <<http://www.phac-aspc.gc.ca/aids-sida/publication/hivtest/index-eng.php>> at 58-63 ("In numerous studies, people change their behaviour after learning they are HIV-positive" at 58).

⁵⁷ This typology is adapted from Mark A. Hall, Mary Anne Bobinski & David Orentlicher, *Health Care Law & Ethics* (New York: Aspen Publishing, 2007) at 923-24. The Canadian HIV/AIDS Legal Network offers a slightly different formulation. In its view, "mandatory testing" includes "requiring HIV testing as a condition of obtaining a certain status, service or benefit, such as employment or health services". Canadian HIV/AIDS Legal Network, "Mandatory and compulsory testing for HIV" in (2007) *HIV Testing* (series of 12 information sheets on HIV testing in Canada), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=713>>. "Compulsory testing" is deemed to be "compelling or forcing a person or group of people to be tested, such that the person cannot choose to refuse testing and cannot legally avoid it" (*ibid.*). See also, Ralf Jürgens, "Mandatory or Compulsory HIV Testing" in *HIV Testing and Confidentiality: Final Report*, (2001) online: <<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=282>>.

blood); an individual can avoid testing by choosing not to participate in the activity. “Routine” HIV testing is not well defined. For some, it involves treating HIV testing like a wide range of other medical tests and procedures for which a general consent to care and treatment is sufficient to authorize the test. Two other approaches to routine testing preserve a more specific informed consent process. Under the “opt-out” approach an individual is told that HIV testing is routine but the person can still “opt-out” or decline testing. Under the “opt-in” approach, individuals are told that HIV testing is routinely offered and they are given an opportunity to agree or to refuse. Opt-in routine testing programs thus resemble more traditional voluntary testing programs, except all persons in a particular group are offered testing.

The UNAIDS/WHO issued a policy statement on HIV testing in 2004 that sought to reinforce the continued necessity for HIV testing to follow the “three C’s” with a focus on confidentiality, counseling, and informed consent.⁵⁸ “Client-initiated”, voluntary counseling and testing programs “remain[ed] critical to the effectiveness of HIV prevention”.⁵⁹ The policy recommended that “routine offer[s] of HIV testing by health care providers” be limited to three populations: to persons being assessed or treated for sexual transmitted diseases, to pregnant women in order to offer treatment designed to reduce the risk of HIV transmission to their offspring, and to patients “seen in clinical and community based health service settings where HIV is prevalent and antiretroviral treatment is available...”.⁶⁰ The policy recommended that systematic, provider-initiated tests falling into these three categories be offered on an “opt-out” basis.⁶¹

The United States pushed routine testing well beyond these recommendations in 2006 when the U.S. Centers for Disease Control (“U.S. CDC”) issued a major new set of recommendations supporting routine, “opt-out” HIV testing for all adults.⁶² The new recommendations gained the support of many health law policy experts and researchers for

⁵⁸ UNAIDS and WHO, “UNAIDS/WHO Policy Statement on HIV Testing” (June 2004), online: <http://www.who.int/ethics/topics/en/hivtestingpolicy_who_unaids_en_2004.pdf>. To be minimally acceptable, the policy provides that the informed consent process include information about “the clinical benefit and the prevention benefits of testing ... the right to refuse ... the follow-up services that will be offered and ... in the event of a positive test result the importance of anticipating the need to inform anyone at ongoing risk who would otherwise not suspect they were being exposed to HIV infection” (*ibid.*, at 2).

⁵⁹ *Ibid.*

⁶⁰ *Ibid.*

⁶¹ *Ibid.*

⁶² Bernard M. Branson *et al.*, “Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings” (2006) 55:RR-14 MMWR 1. The recommendations “are intended for all health-care providers in the public and private sectors” (*ibid.*).

several reasons.⁶³ First, opt-out testing would maintain a voluntary approach to HIV testing. Second, the stringent specific informed consent procedures associated with HIV exceptionalism arguably were no longer warranted given existing strong legal protections from discrimination for HIV-positive persons. Third, the movement of HIV into “low risk” populations meant that many people with HIV infection were unaware they were at risk and were unlikely to seek out testing, making routine screening an important public health tool. Fourth, early identification of HIV infection could be coupled with early medical intervention to improve health care outcomes for persons found to be infected with HIV.

The reactions to the U.S. CDC recommendations were not uniformly positive. Some argued that the move to routine testing was based on a false premise: that the specific informed consent process created a bureaucratic barrier to the expansion of voluntary testing.⁶⁴ Critics also expressed fears about the dilution of voluntariness and suggested that targeted counseling and testing programs would be more efficient and effective.⁶⁵

The U.S. CDC recommendations were followed the next year by new guidelines from UNAIDS/WHO recommending that HIV testing be routinely offered on an opt-out basis to a wider range of populations:

- 1) for all patients ... whose clinical presentation might result from underlying HIV infection; 2) as a standard part of medical care for all patients attending health facilities in generalized HIV epidemics; and 3) more selectively in concentrated and low-level epidemics.⁶⁶

⁶³ See, e.g., Douglas J. Koo *et al.*, “HIV Counseling and Testing: Less Targeting, More Testing” (2006) 96 *Am. J. Public Health* 962; Thomas R. Frieden *et al.*, “Applying Public Health Principles to the HIV Epidemic” (2005) 353 *N. Eng. J. Med.* 2397; Samuel A. Bozzette, “Routine Screening for HIV Infection — Timely and Cost Effective” (2005) 352 *N. Eng. J. Med.* 620; A. David Paltiel *et al.*, “Expanded Screening for HIV in the United States — An Analysis of Cost-Effectiveness” (2005) 352 *N. Eng. J. Med.* 586.

⁶⁴ Ann Hilton Fisher, Catherine Hanssens & David I. Schulman, “The CDC’s routine HIV testing recommendation: legally, not so routine” (2006) 11:2/3 *Canadian HIV/AIDS Pol’y & L. Rev.* 17 at 18.

⁶⁵ Ronald Bayer and Amy L. Fairchild, “Changing the Paradigm for HIV Testing — The End of Exceptionalism” (2006) 355 *N. Eng. J. Med.* 647 at 949; David R. Holtgrave, “Costs and Consequences of the U.S. Centers for Disease Control and Prevention’s Recommendations for Opt-Out HIV Testing” (2007) 4 *PLOS Medicine* 1011; Canadian HIV/AIDS Legal Network, “Outcomes of the Symposium on HIV Testing and Human Rights” (Briefing paper, Montréal, 24-25 October 2005), online: Canadian HIV/AIDS Legal Network <<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=273>>.

⁶⁶ UNAIDS/WHO, “Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities” (2007) at 5, online: <http://www.who.int/hiv/pub/guidelines/9789241595568_en.pdf>; and Madhavi Swamy, “UN agencies issue new guidelines for HIV testing” (2007) 12:2/3 *Canadian HIV/AIDS Pol’y & L. Rev.* 39.

The new guidelines continued to reject the expansion of routine, opt-out testing into lower risk populations: “[h]ealth care providers should *not* recommend HIV testing and counseling to all persons attending all health facilities in settings with low-level and concentrated epidemics, since most people will have a low risk of exposure to HIV”.⁶⁷ The new guidelines recognize that the expansion of HIV screening might require offering pre-test counseling in a modified form, but still retain the general requirements of adherence to the “three C’s — informed consent, counseling and confidentiality”.⁶⁸

Canadian public health authorities generally have supported voluntary HIV testing programs meeting the “three C’s”, with a few exceptions that will be discussed below. The current Canadian testing guidelines provide that “[t]esting should only be carried out with the consent of the person being tested”, and that “Provider-Initiated Testing and Counselling (PITC)” “should be offered to any person with risk behaviour or at risk, any person with clinical or laboratory clues suggestive of HIV infection, or any person who requests it”.⁶⁹

It is estimated that 23-30 per cent of people with HIV infection in Canada are unaware of their status.⁷⁰ Canadian public health authorities have studied the development of policies designed to reach people unaware of their HIV infection but as of early 2008 had not yet joined the U.S. CDC in recommending expansion of routine testing for all adults.⁷¹

⁶⁷ UNAIDS/WHO, *ibid.*, at 8 (emphasis in original).

⁶⁸ *Ibid.*, at 19.

⁶⁹ Public Health Agency of Canada, “HIV Testing and Counselling: Policies in Transition?” (2007) (research paper prepared for the International Public Health Dialogue on HIV Testing and Counseling, Toronto, 17 August 2006), online: <<http://www.phac-aspc.gc.ca/aids-sida/publication/hivtest/index-eng.php>> at 22. The Public Health Agency is studying the possible expansion of routine PITC on an opt-in or opt-out basis (*ibid.*, at 53-57) (discussing benefits and risks of expanded PITC on either an opt-in or opt-out basis).

⁷⁰ *Ibid.*, at 30-32; and Sally Murray and Erica Weir, “HIV Screening” (2005) 173 C.M.A.J. 752.

⁷¹ In 2006, the Public Health Agency of Canada commissioned a research paper focusing on HIV testing and counseling policy related to persons unaware of their HIV infection because they had never been tested or because they had received a false negative result. Public Health Agency of Canada, “HIV Testing and Counselling: Policies in Transition?” (2007) (research paper prepared for the International Public Health Dialogue on HIV Testing and Counseling, Toronto, 17 August 2006), online: <<http://www.phac-aspc.gc.ca/aids-sida/publication/hivtest/index-eng.php>>. The study identified “gaps in knowledge” related to HIV testing, the informed consent process, and other areas (*ibid.*, at 69-71). For an article arguing against the expansion of routine testing in Canada, see Joanne Csete & Richard Elliott, “Scaling up HIV testing: human rights and hidden costs” (2006) 11:1 Canadian HIV/AIDS Pol’y & L. Rev. 1.

The Public Health Agency is expected to release new recommendations regarding HIV testing at some point during 2008.⁷²

Policy recommendations and medical practice guidelines constitute one important determinant of practices regarding HIV testing; however, these policies must operate within a legal framework. The law governing testing programs therefore is another very important determinant of the HIV testing practices in any given jurisdiction. The next sections of this chapter will focus on the legal rules governing testing and the interaction of law and policy in the area of HIV testing in Canada.

(i) *Voluntariness as the General Legal Requirement*

Debates about the proper scope of voluntariness or involuntariness in HIV testing programs are ultimately a combined question of public health policy and law. HIV testing implicates legal rights and obligations at both the provincial and federal levels.⁷³ The first source of legal authority rests with the provinces because of their control of the delivery of health care and the protection of public health.⁷⁴ Whether or not an HIV test can be administered will depend on provincial rules governing public health and regulation of health professions. Common law rules also play an important role, particularly given the informed consent requirement imposed on physicians.

Federal law is relevant in some areas as well, particularly where the testing program intersects with federal authority over international borders or over criminal law. Finally, the rights guaranteed under the *Canadian Charter of Rights and Freedoms* provide significant protections from intrusive testing programs.⁷⁵ Under s. 7 of the *Charter*, “Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental

⁷² Public Health Agency of Canada, “Point-of-Care HIV Testing Using Rapid HIV Test Kits: Guidance for Health-Care Professionals” (2007) 33:S2 CCDR 1, online: <<http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/07pdf/33s2-eng.pdf>> at 2 (noting “[f]urther analysis of legal, ethical, and human rights considerations will be provided in a policy framework to address HIV testing in Canada to be published by the Public Health Agency of Canada (PHAC) in 2008”).

⁷³ See Ralf Jürgens, “Mandatory or Compulsory HIV Testing” in *HIV Testing and Confidentiality: Final Report* (2001), online: <<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=282>>; Joanne Csete & Richard Elliott, “Prevention and Protection: Enhancing Both HIV Testing and Human Rights in Canada” (2007) at 5, online: Canadian HIV/AIDS Legal Network <<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1065>>.

⁷⁴ See *supra*, text accompanying notes 47-50.

⁷⁵ *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

justice.”⁷⁶ Section 8 provides that “Everyone has the right to be secure against unreasonable search or seizure.”⁷⁷ These rights are “subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society”.⁷⁸

All of these sources of law, along with public health guidelines and professional practice standards, point generally to the presumption that HIV testing in Canada should be performed only with the informed consent of the person to be tested. Indeed, HIV testing policies ordinarily involve a relatively elaborate process of pre-test counseling, consent, and post-test counseling.⁷⁹ These policies have not been rooted in specific judicial decisions⁸⁰ or legislation and therefore occasionally spark controversy.

Advances in testing technology now permit both rapid HIV screening and home testing for HIV. Rapid testing is generally considered to provide significant advantages over older screening methods.⁸¹ Yet rapid testing also creates the risk of an expansion of testing to new situations in which truly voluntary testing and counseling may be more difficult to achieve.⁸² The Public Health Agency of Canada recommendations for health care professionals on rapid HIV tests note the importance of adhering to the “three C’s” but recognize the difficulties of

⁷⁶ *Ibid.*, s. 7.

⁷⁷ *Ibid.*, s. 8.

⁷⁸ *Ibid.*, s. 1.

⁷⁹ Public Health Agency of Canada, “HIV Testing and Counselling: Policies in Transition?” (2007) (research paper prepared for the International Public Health Dialogue on HIV Testing and Counseling, Toronto, 17 August 2006), online: <<http://www.phac-aspc.gc.ca/aids-sida/publication/hivtest/index-eng.php>> at 22-26.

⁸⁰ *Ibid.* See also *Canadian AIDS Society v. Ontario*, [1996] O.J. No. 4184, 31 O.R. (3d) 798 (Ont. C.A.), leave to appeal to S.C.C. refused [1997] S.C.C.A. No. 33 (S.C.C.) (court assumes without deciding an issue involving informed consent and HIV testing, noting, “It is better that the issue whether this sense of moral obligation is a legal one be decided in a case which depends upon this issue for its result” (at para. 3)).

⁸¹ See Canadian HIV/AIDS Legal Network, “Rapid HIV testing” in *HIV Testing* (2007) (series of 12 information sheets on HIV testing in Canada), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=713>> at 1 (noting possible benefits of rapid testing include great client satisfaction and increased likelihood that clients will receive results).

⁸² *Ibid.* (noting in particular the risks of rapid HIV testing during labour and delivery); Joanne Csete & Richard Elliott, “Prevention and Protection: Enhancing Both HIV Testing and Human Rights in Canada” (2007) at 5, online: Canadian HIV/AIDS Legal Network <<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1065>> at 20-27 (detailed description of risks, benefits and recommendations for rapid screening); Public Health Agency of Canada, “HIV Testing and Counselling: Policies in Transition?” (2007) (research paper prepared for the International Public Health Dialogue on HIV Testing and Counseling, Toronto, 17 August 2006), online: <<http://www.phac-aspc.gc.ca/aids-sida/publication/hivtest/index-eng.php>> at 50-51.

achieving this standard for tests used in some circumstances, such as during labour and delivery.⁸³

Home testing presents a different set of issues. Should Canadians have access to home tests for HIV infection available in other jurisdictions even though pre- and post-test counseling might be conducted through written materials or phone counselors rather than through face-to-face counseling? Canada's Therapeutic Products Program has not yet approved any home HIV test, in part because of significant concerns about the accuracy of positive or negative results and the suitability of telephone counseling.⁸⁴ Some HIV policy commentators contend that the benefits of expanded testing might outweigh the risks of home testing, at least within a carefully regulated framework.⁸⁵

An even more complex set of issues have been raised by arguments that testing should be expanded and perhaps even mandated when testing will protect health and safety or when the testing will be imposed on individuals whose liberties are restricted, such as prisoners. These issues will be considered in the next section of this chapter.

(ii) *Limits on Voluntariness*

Countries around the world have considered a wide range of HIV testing programs since 1985. Canadian policy-makers have generally resisted calls to make HIV testing mandatory, with only a few exceptions. Proposals to limit the detailed counseling and consent process for HIV testing typically have at least one of three objectives: (1) eliminating "exceptionalism"; (2) protecting health and safety, particularly for third parties; and (3) protecting Canada from the costs and risks of infectious disease. The inclination to expand HIV testing into new spheres is fuelled

⁸³ Public Health Agency of Canada, "Point-of-Care HIV Testing Using Rapid HIV Test Kits: Guidance for Health-Care Professionals" (2007) 33:S2 CCDR 1, online: <<http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/07pdf/33s2-eng.pdf>> at 4. See also Joanne Csete & Richard Elliott, "Prevention and Protection: Enhancing Both HIV Testing and Human Rights in Canada 5" (2007), online: Canadian HIV/AIDS Legal Network <<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1065>> at 20-25.

⁸⁴ Public Health Agency of Canada, "HIV Testing and Counselling: Policies in Transition?" (2007) (research paper prepared for the International Public Health Dialogue on HIV Testing and Counseling, Toronto, 17 August 2006), online: <<http://www.phac-aspc.gc.ca/aids-sida/publication/hivtest/index-eng.php>> at 49-50; Canadian HIV/AIDS Legal Network, "Home HIV testing information sheet" in *HIV Testing* (2007) (series of 12 information sheets on HIV testing in Canada), online: <<http://www.aidslaw.ca/publications/publications/docEN.php?ref=713>>.

⁸⁵ Canadian HIV/AIDS Legal Network, "Home HIV testing information sheet" in *HIV Testing* (2007) (series of 12 information sheets on HIV testing in Canada), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=713>>; "Home HIV testing: Why not in Canada?" (2000) 162 C.M.A.J. 1545.

as well by advances in technology that can reduce the time between test and result to a matter of minutes.⁸⁶ Rapid test results could be used immediately by decision-makers in a broad range of contexts, such as in altering the course of care for women in labour or for guiding the decision of whether to undergo post-exposure prophylactic treatment to reduce the risk of transmission.

Opponents of HIV exceptionalism argue that HIV tests should be treated much like any other test that can provide important information about the health needs of the individual to be tested. HIV testing should be made “routine” whenever administration would be medically appropriate. The definition of “routine” varies. To some, testing could be performed whenever an individual has given a general consent for care and treatment. Others favour routine programs using the “opt-out” or “opt-in” procedures described above. Advocates for making HIV tests routine note the benefits to be derived by the individual and to society from the early identification and possible treatment of HIV infection. Opponents of routine HIV testing note that HIV testing carries special emotional, social and financial risks due to the stigma and discrimination still associated with the disease. Opponents also express skepticism about the benefits of testing in the absence of counseling, support services, and adequate medical treatment.

There has been a shift toward making HIV testing programs more routine in at least some circumstances over the past decade. One example involves the routine screening of pregnant women and/or newborns. Public health authorities and legislatures in the United States moved toward opt-out routine HIV screening for pregnant women and routine or mandatory screening for newborns once therapies became available to reduce the risk of perinatal transmission.⁸⁷ Most Canadian provinces have implemented some version of routine perinatal HIV screening program, most often via guidelines issued by public health officials or physician groups.⁸⁸ Provinces differ in offering either “opt-in” or “opt-out” routine

⁸⁶ See generally Canadian HIV/AIDS Legal Network, “Rapid HIV testing” in *HIV Testing* (2007) (series of 12 information sheets on HIV testing in Canada), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=713>>; and Public Health Agency of Canada, “Point-of-Care HIV Testing Using Rapid HIV Test Kits: Guidance for Health-Care Professionals” (2007) 33:S2 CCDR 1, online: <<http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/07pdf/33s2-eng.pdf>>.

⁸⁷ See, e.g., U.S. CDC, “Revised Recommendations for HIV Screening in Pregnant Women” (9 November 2001) 50 MMWR Recomm Rep. (RR19) 59. Some jurisdictions in the U.S. began to require HIV screening for newborns, with or without parental consent. U.S. CDC, “HIV Testing Among Pregnant Women — United States and Canada, 1998-2001” (15 November 2002) 51 MMWR 1013.

⁸⁸ See David R. Burdge *et al.*, “Canadian consensus guidelines for the management of pregnant HIV-positive women and their offspring” (24 June 2003) 168 C.M.A.J. 1683.

perinatal screening.⁸⁹ The “opt-out” programs are generally thought to result in higher levels of HIV testing but public health officials in Ontario have been able to achieve similar rates in an “opt-in” testing program.⁹⁰ A study of Alberta’s “opt-out” program demonstrates high rates of testing but also raises concerns given that only two-thirds of respondents “always informed women that they have a choice to decline” testing.⁹¹

The second challenge to the principle of voluntariness has come in cases where it has been argued that less-than-totally-voluntary testing will protect the health and safety of third parties. Proponents of routine HIV screening note that individuals receiving positive results can change their behaviour to avoid transmitting the virus to others. The clearest and least controversial example of testing to protect third parties occurs during the blood donation process in Canada and elsewhere.⁹² Screening programs

online: Canadian Medical Association Journal <<http://www.cmaj.ca/cgi/data/168/13/1671/DC1/1>> (note that appendix is available only online); U.S. CDC, “HIV Testing Among Pregnant Women — United States and Canada, 1998-2001” (15 November 2002) 51 MMWR 1013 (reporting higher rates of HIV testing in Provinces with “opt-out” than in “opt-in” testing programs); Gayatri C. Jayaraman, Jutta K. Preiksaitis & Bryce Larke, “Mandatory reporting of HIV infection and opt-out prenatal screening for HIV infection: effect on testing rates” (18 March 2003) 168 C.M.A.J. 679 (increase in testing rates associated with opt-out prenatal testing program).

⁸⁹ Public Health Agency of Canada, “HIV Testing and Counselling: Policies in Transition?” (2007) (research paper prepared for the International Public Health Dialogue on HIV Testing and Counselling, Toronto, 17 August 2006), online: <<http://www.phac-aspc.gc.ca/aids-sida/publication/hivtest/index-eng.php>> at 26-27. Seven provinces and territories offer opt-out testing. Public Health Agency of Canada, “HIV/AIDS Epi Updates, November 2007” at 43-44 (Alberta, Manitoba, New Brunswick, Newfoundland and Labrador, Québec, the Northwest Territories and Nunavut). Three provinces use the opt-in strategy (British Columbia, Yukon, Saskatchewan, Nova Scotia, Ontario and Prince Edward Island) (*ibid.*).

⁹⁰ “Opt-in” programs generally have lower rates of testing than “opt-out” programs; however, Ontario demonstrated that “a high rate of HIV testing for pregnant women can be achieved through voluntary opt-in testing using multiple approaches to promote the intervention ... [O]verall the rates currently being achieved are as high as some jurisdictions using the opt-out approach”. Public Health Agency of Canada, “HIV Testing and Counselling: Policies in Transition?” (2007) (research paper prepared for the International Public Health Dialogue on HIV Testing and Counselling, Toronto, 17 August 2006), online: <<http://www.phac-aspc.gc.ca/aids-sida/publication/hivtest/index-eng.php>> at 26-27.

⁹¹ *Ibid.*, at 27.

⁹² See for example Canadian Blood Services, “HIV and AIDS”, online: <http://www.bloodservices.ca/CentreApps/Internet/UW_V502_MainEngine.nsf/page/E_HIV+and+AIDS?OpenDocument> (discussing testing policy). There appears to be little debate about the necessity for and validity of HIV testing for donors or blood or other tissues/organs capable of transmitting HIV. Ralf Jürgens, “Consent” in *HIV Testing and Confidentiality: Final Report* (2001), online: Canadian HIV/AIDS Legal Network <<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=282>>. Unlinked anonymous screening (“UAS”) of blood and tissue samples is also conducted without specific informed consent of individual though within a carefully reviewed ethical framework (*ibid.*); D. Coburn, “Guidelines on ethical and legal considerations in anonymous unlinked HIV seroprevalence research” (1991) 144 C.M.A.J. 1603.

for pregnant women and newborns, discussed above, could be justified on this basis. Other, more controversial proposals advanced but not broadly accepted include mandatory HIV-testing for health care patients, health care providers, or prisoners.⁹³

One form of testing to protect third parties — post-exposure testing — has gained legislative and judicial support in Canada. In general, post-exposure testing involves allowing a person exposed to the blood or body fluids of another to require the “source” individual to undergo testing for HIV or other bloodborne pathogens. Those favouring post-exposure testing argue that it can provide important information that could be used to make decisions about whether to undergo prophylactic anti-retroviral treatment to reduce the risk of HIV transmission.⁹⁴ The availability of rapid testing has increased the strength of this justification because prophylactic treatment must be started quickly to maximize effectiveness. Critics of post-exposure testing argue that the results usually are ambiguous and often useless by the time they are obtained;⁹⁵ they

⁹³ Some health care providers have argued that routine HIV screening should be employed before patients undergo surgical procedures that might present a risk of HIV exposure to their caregivers. See Canadian HIV/AIDS Legal Network, “Mandatory and compulsory testing for HIV” in *HIV Testing* (2007) (series of 12 information sheets on HIV testing in Canada), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=713>> at 1 (discussing proposals to test health care patients); K. Chapman *et al.*, “Testing patients for HIV before surgery: the views of doctors performing surgery” (1995) 7 *AIDS Care* 125 (significant percentage of anonymously surveyed doctors at two London teaching hospitals favoured some sort of mandatory screening). Publicity surrounding an HIV-infected surgeon in Montréal led the Québec Medical Association to adopt a policy requiring physicians to know their HIV status and for HIV-positive physicians to disclose the information to their employers. Canadian HIV/AIDS Legal Network, “Mandatory and compulsory testing for HIV” in *HIV Testing* (2007) (series of 12 information sheets on HIV testing in Canada), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=713>> at 1-2 (noting policy and disputing rationale). A correctional officers union proposed amending federal legislation to permit “compulsory testing of inmates in federal prisons for HIV and other infectious diseases” (*ibid.*) (noting 2006 proposal and disputing the rationale).

⁹⁴ Post-exposure prophylactic (“PEP”) treatment to prevent HIV infection should be started within hours of the exposure to be effective: U.S. CDC, “Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis” (30 September 2005) 54 *MMWR Recomm Rep.* (RR9) 1, 8.

⁹⁵ If common antibody tests are used, a negative test result does not mean that the source individual is uninfected; the person could have a recent HIV infection without having detectable HIV antibodies, resulting in a false negative test result. Critics of post-exposure testing argue that the unreliability of a negative test eliminates the utility of testing: persons exposed to the blood or body fluids of another might just proceed on the assumption that they might have been exposed to HIV. Proponents of post-exposure testing argue that a positive antibody test result would be meaningful to a person deciding whether to undergo PEP and that directly testing for viral RNA would be even more effective. See, Canadian HIV/AIDS Legal Network, “Mandatory and compulsory testing for HIV” in *HIV*

therefore contend any benefits from testing are greatly outweighed by the intrusion on individual liberty associated with a mandatory test.

The post-exposure testing debate in Canada involves many different types of possible exposure to HIV. Some persons may have been exposed to HIV during a sexual assault or other crime involving exposure to bodily substances. Other people may have been exposed to HIV when providing emergency medical care, such as the scene of accidents. Police officers or correctional employees are sometimes exposed to bodily fluids from suspects or prisoners in their custody. More broadly, health care providers may be exposed to the bodily fluids of patients due to exposure incidents in providing non-emergency care, such as through needle-sticks.

The early debate arose in the courts when survivors of sexual offences asked that the accused or convicted sex offender undergo testing for HIV. Until relatively recently, there was no statutory authorization for this type of testing in Canada.⁹⁶ Post-exposure testing of persons convicted or accused of sexual offences was permitted in other jurisdictions such as in the United States.⁹⁷ Concerns about the true benefits of testing are particularly acute in these cases as the time lag between exposure and testing is likely to be quite long. A Québec court rejected a request for testing where the source individual was merely accused of committing the offence.⁹⁸ In *R. v. J.P.B.*, the court entered an order requiring HIV testing of a defendant convicted of sexual assault.⁹⁹ The case is only of narrow applicability because the order was based on a general authorization for judicial orders under the *Young Offenders Act*.¹⁰⁰ An Ontario trial court

Testing (2007) (series of 12 information sheets on HIV testing in Canada), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=713>> at 2-3. In a few reported decisions, criminal defendants have agreed to undergo HIV testing. See, e.g., *R. v. Luu*, [2006] O.J. No. 1083, 2006 CarswellOnt 1689 (Ont. C.J.); and *R. v. T. (J.E.)*, [2005] B.C.J. No. 206, 2005 BCPC 26, [2005] B.C.W.L.D. 2843, [2005] W.D.F.L. 1885 (B.C. Prov. Ct.).

⁹⁶ Canadian HIV/AIDS Legal Network, "Mandatory and compulsory testing for HIV" in *HIV Testing* (2007) (series of 12 information sheets on HIV testing in Canada), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=713>> at 2-3.

⁹⁷ William E. Adams, Jr. et al., *AIDS: Cases and Materials* (Durham: Carolina Academic Press, 2002) at 90-97.

⁹⁸ Canadian HIV/AIDS Legal Network, "Rapid HIV Screening at the Point of Care: Legal and Ethical Questions" (2000) at 61, online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=284>> (citing *R. v. Beaulieu*, [1992] J.Q. no 2046, [1992] R.J.Q. 2959, (Que. Ct.))

⁹⁹ *R. v. J.P.B.*, [1992] N.W.T.J. No. 207, [1993] N.W.T.R. 65, [1993] 2 W.W.R. 414 (N.W.T. Terr. Ct.) [*J.P.B.* cited to N.W.T.R.]. See also Canadian HIV/AIDS Legal Network, "Rapid HIV Screening at the Point of Care: Legal and Ethical Questions" (2000), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=284>> at 61.

¹⁰⁰ The court noted that "pursuant to the *Young Offenders Act*, s. 20(1), an Order may be made which is in the best interest of the young person and the public" and may "impose on the young person such other reasonable and ancillary conditions as it deems advisable and in the best interest of the young person and the public" (*J.P.B.*, *ibid.* at para. 10).

also issued an order compelling a person convicted of sexual assault to undergo HIV testing, but the same judge later refused to enter a new testing order involving the same parties, noting that “[i]n the absence of statutory authority, the court must proceed with caution”.¹⁰¹ What little case law there is thus suggests that courts in Canada would be reluctant to authorize post-exposure testing in sexual assault cases without statutory authorization.

The Uniform Law Conference of Canada issued a report and a model act governing post-exposure testing in 2004.¹⁰² The Model Act represents an effort to balance “[s]ource individuals’ *Charter*-protected rights to privacy and security” against “the interests of exposed individuals, the interests of other individuals, and the public interest in their health and well being”.¹⁰³ The Act broadly covers individuals exposed to the source individual’s bodily substances “as a result of being a victim of crime”; “while providing emergency health services or emergency first aid to that individual”; or “while performing any prescribed function in relation to that individual”.¹⁰⁴ The Act requires evidence in the form of a physician’s report that there is a significant

¹⁰¹ *C. (D.) v. 371148 Ontario Ltd.*, [1997] O.J. No. 2367, 13 C.P.C. (4th) 132 (Ont. Gen. Div.), Macdonald J. The case involved Paul Bernardo. The original order was unpublished but the court reproduced the terms in a subsequent proceeding (at para. 1):

In September 1996, I ordered that the Defendant, Paul Bernardo, submit himself for testing for AIDS and other sexually transmitted diseases by providing a sufficient quantity of blood samples for that purpose. I reproduce paragraphs 1 and 2 of the September order. ...

THIS COURT ORDERS that the Defendant Paul Bernardo presently in the custody of Correctional Services, Canada submit himself for testing for aids [*sic*] and other sexually transmitted diseases and provide a duly qualified medical person appointed by Correctional Services, Canada with a sufficient quantity of his blood for that purpose. ...

¹⁰² Uniform Law Conference of Canada (Mandatory Testing and Disclosure Working Group), *Uniform Mandatory Testing and Disclosure Act (Draft and Commentary)*, n.d., online: <http://www.ulcc.ca/en/us/Uniform_Mandatory_Testing_and_Disclosure_Act_Draft_En.pdf> [*Uniform Mandatory Testing and Disclosure Act*]. The report notes that

[u]nder current law, an individual exposed to the risk of communicable disease infection ... does not have an efficacious means to compel the source individual to provide a bodily sample for assessment and treatment purposes. The lack of this type of legal mechanism is a particular concern for emergency services providers, peace officers, and correctional officers ... [who] may be exposed to risks of communicable disease infection in the course of their work ...

Ibid., at 1. For a discussion of the Model Act and related legislative initiatives, see Richard Elliott, “Undue Force: An Overview of Provincial Legislation on Forced Testing for HIV” (2007), online: Canadian HIV/AIDS Legal Network <<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1210>>.

¹⁰³ *Uniform Mandatory Testing and Disclosure Act*, *ibid.*, at 1.

¹⁰⁴ *Ibid.*, at 5-6 (s. 3).

health risk to the exposed person.¹⁰⁵ The Act gives an exposed individual the right to seek a testing order from a provincial superior court requiring that a medical officer ensure that a sample is taken and analysed by appropriate personnel.¹⁰⁶ The Act puts in place restrictions on the use of the test result.¹⁰⁷

Four provinces — Alberta, Nova Scotia, Ontario and Saskatchewan — now have legislation based on the Model Act.¹⁰⁸ These provinces have followed the basic structure of the Act while modifying the group of exposed persons, the application procedures and the penalties for offences. For example, Alberta's statute focuses on persons who "ha[ve] come into contact with a bodily substance of a source individual ... while providing emergency assistance" or "while performing duties as a firefighter, paramedic or peace officer".¹⁰⁹ It does not expressly cover persons who might have been exposed to bodily substances as the result of criminal conduct. The Alberta legislation is unique in that it authorizes issuance of a testing order that requires the medical officer to check the "communicable diseases databases", which might mean that the source individual is never required to provide a sample.¹¹⁰

Ontario covers the categories of exposed persons identified in the Model Act but then adds a new category: a person exposed "[i]n the course of his or her duties, if the person belongs to a prescribed class".¹¹¹ The regulations provide that the "prescribed class" includes correctional employees, employees of police forces, firefighters, paramedics and paramedic students, nurses, physicians, and medical students.¹¹² Ontario thus appears to have greatly expanded the scope of mandatory testing to cover a wide range of occupational exposures.

¹⁰⁵ *Ibid.*, at 8 (s. 4).

¹⁰⁶ *Ibid.*, at 1-2. Under the Act, "[d]isobeying a testing order is an offense". *Ibid.*, at 2.

¹⁰⁷ *Ibid.*, at 2.

¹⁰⁸ Some of these jurisdictions now also have issued regulations under the Acts. See, e.g., *Mandatory Testing and Disclosure Act*, S.A. 2006, c. M-3.5; *Mandatory Testing and Disclosure Regulation*, Alta. Reg. 190/2007; *Mandatory Testing and Disclosure Act*, S.N.S. 2004, c. 29; *Mandatory Testing and Disclosure Regulations*, O.I.C. 2006-246, N.S. Reg. 75/2006; *Mandatory Blood Testing Act, 2006*, S.O. 2006, c. 26; O. Reg. 449/07; *Mandatory Testing and Disclosure (Bodily Substances) Act*, S.S. 2005, c. M-2.1. See also Richard Elliott, "Undue Force: An Overview of Provincial Legislation on Forced Testing for HIV" (2007), online: Canadian HIV/AIDS Legal Network <<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1210>> (analyzing the legislation).

¹⁰⁹ *Mandatory Testing and Disclosure Act*, S.A. 2006, c. M-3.5, s. 3(1). The Act also covers individuals "while being involved in a circumstance or activity described in the regulations", but the regulations are silent on this point (*ibid.*): Alta. Reg. 190/2007 (*Mandatory Testing and Disclosure Regulation*).

¹¹⁰ *Mandatory Testing and Disclosure Act*, S.A. 2006, c. M-3.5, s. 4(3).

¹¹¹ *Mandatory Blood Testing Act, 2006*, S.O. 2006, c. 26, s. 2.

¹¹² Reg. 449/07, s. 3.

There are also significant differences in the provincial rules governing the timeline for applications and orders, the strength of the rules protecting the confidentiality of the sample and test results, and the penalties for violation of the mandatory testing schemes.¹¹³ Critics of post-exposure testing argue that it violates the *Charter*;¹¹⁴ given the often-limited benefits of post-exposure testing for the person exposed, courts may be unwilling to find the intrusion on bodily integrity or the search and seizure of blood samples to be reasonable or necessary.¹¹⁵

The final justification for the expansion of HIV testing involves the protection of countries from the “importation” of disease as well as from the expenses associated with providing medical treatment. These HIV testing programs have been repeatedly rejected in international guidelines.¹¹⁶ The United States recently moved to amend its immigration law to permit persons with HIV to obtain visas.¹¹⁷

¹¹³ Richard Elliott, “Undue Force: An Overview of Provincial Legislation on Forced Testing for HIV” (2007), online: Canadian HIV/AIDS Legal Network <<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1210>> (analysing the legislation).

¹¹⁴ See for example Richard Elliott, “Undue Force: An Overview of Provincial Legislation on Forced Testing for HIV” (2007), online: Canadian HIV/AIDS Legal Network <<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1210>> at 19-20; Canadian HIV/AIDS Legal Network, “Rapid HIV Screening at the Point of Care: Legal and Ethical Questions” (2000), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=284>> at 51-52; Theodore de Bruyn, “Occupational Exposure to HIV and Forced HIV Testing: Questions and Answers” (2002), online: Canadian HIV/AIDS Legal Network <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=278>>.

¹¹⁵ Richard Elliott, “Undue Force: An Overview of Provincial Legislation on Forced Testing for HIV” (2007), online: Canadian HIV/AIDS Legal Network <<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1210>> at 19-20. See also Richard Elliott, “Legislation to Authorize Forced Testing for HIV in the Event of Occupational Exposure: An Unjustified and Unnecessary Rights Violation: A submission to the Government of Manitoba” (April 2008) at 17-26, online: Canadian HIV/AIDS Legal Network, <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=849>>. The *Charter*’s protection of privacy will be considered in Section III (c), below.

¹¹⁶ Joint United Nations Programme on HIV/AIDS (UNAIDS) and International Organization for Migration (IOM), “UNAIDS/IOM Statement on HIV/AIDS-Related Travel Restrictions” (June 2004) at 3 (citing statements of other international organizations), online: UNAIDS <http://www.unaids.org/en/PolicyAndPractice/KeyPopulations/PeopleHIV/mobility_technical_policies.asp>. Continuing concerns about the issue led UNAIDS to establish a new International Task Team on HIV-related Travel Restrictions charged with drafting new recommendations “toward the elimination of HIV-specific restrictions”. See “Third meeting of the International Task Team on HIV-related Travel Restrictions” (18 July 2008) (noting that recommendations expected to be finalized and submitted in November/December 2008), online: UNAIDS <http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2008/20080718_travel_restrictions.asp>.

¹¹⁷ Associated Press, “House Passes Broader Plan to Fight AIDS” *The New York Times* (2 July 2008), online: *The New York Times* <<http://www.nytimes.com/2008/07/25/washington/25aids.html?ref=world>> (House sending bill to President for signature amending 8 U.S.C.A. §1182 (West 2007) which provided that aliens ineligible for a visa or admission

Under Canada's federal *Immigration and Refugee Immigration Act*¹¹⁸ and regulations, various categories of visitors and immigration applicants are required to undergo a medical examination, which can include routine testing for HIV infection.¹¹⁹ Canada no longer argues that HIV testing is necessary to protect public health, except for visitors intending to work in certain jobs which are likely to present the risk of exposure to their blood or body fluids.¹²⁰ The immigration testing rules are instead justified as necessary to implement the Act's provisions making inadmissible certain categories of applicants who are "reasonably ... expected to cause excessive demand on health or social services".¹²¹ Limits on the *Charter's* applicability¹²² restrict legal challenges to HIV testing in this area.

included those "who ... [were] determined (in accordance with regulations prescribed by the Secretary of Health and Human Services) to have a communicable disease of public health significance, which shall include infection with the etiologic agent for acquired immune deficiency syndrome").

¹¹⁸ *Immigration and Refugee Protection Act*, S.C. 2001, c. 27.

¹¹⁹ Citizenship and Immigration Canada, *Designated Medical Practitioner Handbook*, online: <<http://www.cic.gc.ca/english/resources/publications/dmp-handbook/index.asp>>. See also Canadian HIV/AIDS Legal Network, "Canada's immigration policy as it affects people living with HIV/AIDS" (February 2007), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=97>>.

¹²⁰ *Immigration and Refugee Protection Regulations*, S.O.R./2002-227, s. 30(1)(b). See also Canadian HIV/AIDS Legal Network, "Canada's immigration policy", *ibid.*

¹²¹ *Immigration and Refugee Protection Act*, S.C. 2001, c. 27 ("IRPA"), s. 38(1)(c). See also, Tim Fankin, "Supreme Court clarifies immigration medical inadmissibility provision" (2006) 11:1 Canadian HIV/AIDS Pol'y & L. Rev. 37 (discussing whether S.C.C. decision requiring individualized determination in case of business-class immigrants involving excessive demand on social services might be applied to cases involving claims of excessive demand on the public health system due to HIV infection).

¹²² For an extensive commentary, see Canadian HIV/AIDS Legal Network, "HIV/AIDS and Immigration: Final Report" (2001), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=103>>. See also *Chiarelli v. Canada (Minister of Employment & Immigration)*, [1992] S.C.J. No. 27, [1992] 1 S.C.R. 711, 90 D.L.R. (4th) 289 (S.C.C.) (discussing interaction of s. 6 of the *Charter*, governing mobility rights, with the *Immigration Act*, 1976, S.C. 1976-77, c. 52); *Chesters v. Canada (Minister of Citizenship & Immigration)*, [2002] F.C.J. No. 992, [2003] 1 F.C. 361 (F.C.T.D.) (examining application of *Charter* to case involving medical examination; noting that entry into Canada by persons who are not citizens or permanent residents "is a privilege and its grant lies within the purview of the Canadian government ..." (*ibid.*, at para. 120)). See also *Covarrubias v. Canada (Minister of Citizenship and Immigration)*, [2006] F.C.J. No. 1682, 2006 FCA 65, [2007] 3 F.C.R. 169 (F.C.A.) (*in dicta* dealing with statutory interpretation, noting that "where a country makes a deliberate attempt to persecute or discriminate against a person by deliberately allocating insufficient resources for the treatment and care of that person's illness or disability, as has happened in some countries with patients suffering from HIV/AIDS, that person may qualify under ... [subparagraph 97(1)(b)(iv) of the *IRPA*], for this would be refusal to provide the care and not inability to do so" (*ibid.*, at para. 39)).

(c) Privacy, Confidentiality and Reporting to Public Health Authorities**(i) Privacy and Confidentiality**

An HIV test involves more than an invasion into one's bodily integrity and revelation of personal information. The value (and potential harm) of testing is closely related to the use made of the test results. A test on its own is useless; the result must be given to someone — such as the person tested — for the test to be meaningful. Different testing techniques yield different amounts of information about the person tested. Anonymous testing reveals the least information as the person undergoing testing uses a code to retrieve their result. “Non-nominal” testing also uses a code system rather than the individual's name, but the physician ordering the test will know the identity of the person tested. Under “nominal” testing, the identity of the person being tested is readily linked to the test result. Anonymous testing is sometimes controversial: anonymity may encourage some to undergo testing but this same characteristic might make it difficult for health care providers to provide follow-up or to collect accurate data about the spread of the infection in a population.¹²³

Information about positive test results theoretically could be made available for use in everything from individual medical decisions to government budget planning. Individuals infected with HIV generally seek to limit disclosure of the information to prevent stigma and discrimination.¹²⁴ The release of HIV-related information is subject to legal constraints at both the provincial and federal levels of government.¹²⁵

¹²³ Public Health Agency of Canada, “HIV Testing and Counselling: Policies in Transition?” (2007) (research paper prepared for the International Public Health Dialogue on HIV Testing and Counseling, Toronto, 17 August 2006), online: <<http://www.phac-aspc.gc.ca/aids-sida/publication/hivtest/index-eng.php>> at 24-26.

¹²⁴ Public Health Agency of Canada, “HIV Testing and Counselling: Policies in Transition?” (2007) (research paper prepared for the International Public Health Dialogue on HIV Testing and Counseling, Toronto, 17 August 2006), online: <<http://www.phac-aspc.gc.ca/aids-sida/publication/hivtest/index-eng.php>> at 46-47 (discussing issues of stigma and discrimination for people living with HIV infection); and Canadian HIV/AIDS Legal Network, “Confidentiality” in *HIV Testing* (2007) (series of 12 information sheets on HIV testing in Canada), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=713>>. See also Richard Elliott & Jennifer Gold, “Protection against discrimination based on HIV/AIDS status in Canada: the legal framework” (2005) 10:1 Canadian HIV/AIDS Pol’y & L. Rev. 20.

¹²⁵ See generally Canadian HIV/AIDS Legal Network, “Privacy Protection and the Disclosure of Health Information: Legal Issues for People Living with HIV/AIDS in Canada” (2004), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=189>>; and Canadian HIV/AIDS Legal Network, “Confidentiality” in *HIV Testing* (2007) (series of 12 information sheets on HIV testing in Canada), online: <<http://www.aidslaw.ca/>>

Once again, some of the key debates involve determining the proper level of governmental regulation; balancing the individual's liberty interests with the need to protect health and safety; and promoting or avoiding HIV exceptionalism. The remainder of this subsection will review the scope of legal protection for the confidentiality of HIV-related information. Subsection III (c) (i) in this chapter will apply these principles to a key public health strategy focused on case identification: names-based reporting of HIV infection to public health authorities in Canada.

There are many potential sources of an obligation to limit the disclosure of HIV test results. The Canadian HIV/AIDS Legal Network, in its extensive report on privacy protections for persons with HIV infection, suggests distinguishing between an individual's right to privacy, a duty owed by some persons in some circumstances to maintain confidentiality, and the evidentiary rules of privilege.¹²⁶ Despite the number of sources protecting the privacy of some types of information, an individual with HIV infection does not have the absolute right to control the disclosure of information about his or her status. Each source of protection has limits and exceptions.

Canadian courts have found a constitutionally-protected right of privacy in the *Charter*, particularly ss. 7 and 8.¹²⁷ (For further discussion, see Chapter 4, "Public Health Information Privacy and Confidentiality".) In contrast to the relatively robust constitutional protection of privacy interests, privacy has not been well-protected at common law in Canada.¹²⁸ In *Caltagirone v. Scozzari-Cloutier*, the court considered whether a plaintiff's aunt could be held liable for disclosing his HIV status to other

publications/publicationsdocEN.php?ref=713>. See also, Special Issue: Privacy Law (2006) 43:3 Alta. L. Rev. 549-551.

¹²⁶ Canadian HIV/AIDS Legal Network, "Privacy Protection and the Disclosure of Health Information: Legal Issues for People Living with HIV/AIDS in Canada" (2004), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=189>> at 2-3.

¹²⁷ Section 7 of the *Charter* gives "[e]veryone ... the right to ... liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice": *Canadian Charter of Rights and Freedoms*, s. 7, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11. Section 8 gives "[e]veryone the right to be secure against unreasonable search or seizure" (*ibid.*). See also Richard B. Bruyer, "Privacy: A Review and Critique of the Literature" (2006) 43 Alta. L. Rev. 553 (critiquing grounding of privacy in liberty).

¹²⁸ Canadian HIV/AIDS Legal Network, "Privacy Protection and the Disclosure of Health Information: Legal Issues for People Living with HIV/AIDS in Canada" (2004), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=189>> at 17. See also Russell Brown, "Rethinking Privacy: Exclusivity, Private Relation and Tort Law" (2006) 43 Alta. L. Rev. 589; Robyn M. Ryan Bell, "Tort of Invasion of Privacy — Has its Time Finally Come?" in Todd Archibald & Michael Cochrane, eds., *Annual Review of Civil Litigation* (Toronto: Thomson Carswell, 2005) at 225.

relatives of the plaintiff during a “heated argument”.¹²⁹ The court rejected a claim for intentional infliction of emotional distress because the defendant did not have the requisite intent to cause the plaintiff any mental distress.¹³⁰ The court noted the lack of guidance regarding the principles to be used in common law breach of privacy claims¹³¹ and offered its own analysis of the essential elements.¹³² The court concluded that the aunt’s conduct constituted an actionable breach of privacy but that the plaintiff had failed to prove that the breach caused his injuries.¹³³

Some types of relationships — such as the physician-patient relationship — give rise to specific confidentiality duties,¹³⁴ as may standards of care applicable to health care professionals and facilities.¹³⁵

The balance between individual liberty and other public needs noted in the constitutional analysis is repeated under the common law. The common law duty to maintain confidentiality typically includes a series of exceptions designed to protect the patient, other individuals, and society at

¹²⁹ *Caltagirone v. Scozzari-Cloutier*, 2007 WL 3077446, 2007 CarswellOnt 6753 (Ont. S.C.J.).

¹³⁰ *Ibid.*, at paras. 6-9.

¹³¹ *Ibid.*, at paras. 10-13.

¹³² According to the court:

[T]he tort could be structured through answers to the following questions:

1. Is the information acquired, collected, disclosed or published of a kind that a reasonable person would consider private?
2. Has the Plaintiff consented to acquisition or collection of the information?
3. If not, has the information been acquired or collected for a legal process or public interest reason? If so, what is that reason?
4. Has the Plaintiff consented to disclosure or publication of the information?
5. If not, has the information been disclosed or published for a legal process or public interest reason? If so, what is that reason?
6. Is the legal process or public interest reason put forward for acquisition, collection, disclosure or publication one that a reasonable person would consider outweighs the interest of the individual in keeping the information private? ...

If, at the end of the analysis, one finds either no legal process or public interest reason for acquisition, collection, disclosure or publication of the information, or the legal process or public interest reason is outweighed by the private interest, then an actionable breach of privacy has occurred.

Ibid., at paras. 21-22.

¹³³ *Ibid.*, at paras. 23-33.

¹³⁴ Canadian HIV/AIDS Legal Network, “Privacy Protection and the Disclosure of Health Information: Legal Issues for People Living with HIV/AIDS in Canada” (2004), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=189>> at 18-19. See also *McInerney v. MacDonald*, [1992] S.C.J. No. 57, [1992] 2 S.C.R. 138, 93 D.L.R. (4th) 415 (S.C.C.).

¹³⁵ See, e.g., *Peters-Brown v. Regina District Health Board*, [1995] S.J. No. 609, 136 Sask. R. 126 (Sask. Q.B.), aff’d [1996] S.J. No. 761, 148 Sask. R. 248 (Sask. C.A.).

large.¹³⁶ There is little Canadian case law on the existence or scope of exceptions to the common law duty of physicians or others to maintain the confidentiality of information. The leading case actually involves the evidentiary privilege attached to solicitor-client communications.

Evidentiary privileges differ from the traditional duty to protect confidentiality because they arise only in the specialized setting of judicial proceedings. Common law jurisdictions in Canada provide the strongest privilege to solicitor-client and spousal communications; “communications between a health professional and a patient” are subject to a “case-by-case” privilege analysis.¹³⁷ The fact that the existence and scope of the privilege is determined on a case-by-case basis creates uncertainty about the scope of evidentiary protection for patient information.¹³⁸

Canadian jurisdictions, unlike those in the United States, have not enacted special HIV confidentiality statutes and thus avoided the HIV exceptionalism debate in this area. Canadians have focused on improving general privacy protections, but concerns about the disclosure of HIV-related information have not fuelled the debate. Instead, interest in privacy protection has been driven by the perception that computerized medical records and the electronic transmission of data have created a greater threat to the confidentiality of sensitive information.¹³⁹ Medical information stored electronically is potentially subject to broader dissemination than the information contained in the traditional patient medical file. In addition, the information may be accessible to a broad range of persons or institutions, limiting the utility of the narrow confidentiality protections found within the physician-patient relationship.

¹³⁶ See generally Mark A. Hall, Mary Anne Bobinski & David Orentlicher, *Health Care Law & Ethics* (New York: Aspen Publishing, 2007) at 185-96.

¹³⁷ Canadian HIV/AIDS Legal Network, “Privacy Protection and the Disclosure of Health Information: Legal Issues for People Living with HIV/AIDS in Canada” (2004), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=189>> at 20-21.

¹³⁸ *Ibid.*, at 20-21 (discussing application of “Wigmore criteria” in determining existence and scope of the privilege).

¹³⁹ See for example Nola M. Ries, “Patient Privacy in a Wired (and Wireless) World: Approaches to Consent in the Context of Electronic Health Records” (2006) 43 *Alta. L. Rev.* 681 (reviewing developments in electronic records and trends that may reduce privacy and consent constraints while increasing the need to focus on records security); Nola M. Ries & Geoff Moysa, “Legal Protections of Electronic Health Records: Issues of Consent and Security” (2005) 14:1 *Health L. Rev.* 18 (reviewing development of electronic records, the risks and benefits of these records, and the regulatory framework); Public Health Agency of Canada, “HIV Testing and Counselling: Policies in Transition?” (2007) (research paper prepared for the International Public Health Dialogue on HIV Testing and Counselling, Toronto, 17 August 2006), online: <<http://www.phac-aspc.gc.ca/aids-sida/publication/hivtest/index-eng.php>> at 8 (noting that confidentiality “has required continuous reinforcement in agency and institutional policies as well as education of health care workers and communities because confidentiality is often breached both within institutions and communities”).

Privacy therefore is increasingly subject to protection by federal and provincial legislation — so much so that it is sometimes difficult to determine which slightly different sets of rules will apply to a particular situation.

The ever-expanding array of privacy-related legislation can be roughly analyzed according to several criteria: federal or provincial enactment; the types of entities/individuals given an obligation to maintain confidentiality; the types of information protected; the expansiveness of exceptions or exclusions from protection; and the strength of the enforcement system.¹⁴⁰ Professor Gibson's chapter in this volume provides a more detailed discussion of the intricacies of privacy legislation.

This section began with the observation that HIV testing carries with it a series of questions about the use of test results. The analysis of the wide range of legal doctrines and rules governing the disclosure of HIV-related information suggests that individuals have a general right to control the disclosure of health information, including information about HIV infection. Yet there are significant exceptions to this principle. The *Charter* protects individuals from invasions of privacy, except where permitted by s. 8 or where disclosure is necessary to serve a "substantial" interest,¹⁴¹ so long as the infringement on privacy is "reasonable and demonstrably justified".¹⁴² Common law protections are relatively weak and contain exceptions for disclosures required by law or related to the need to protect public health or safety. Statutory and regulatory provisions at the federal and provincial levels have expanded the scope of protection to a broader range of actors but continue to include significant exceptions. Section III (c) (ii) will focus on a key debate, which pits individual privacy interests against the governmental interest in collecting information about cases of HIV infection.

(ii) Names-Based HIV Reporting to Public Health Authorities

As noted in Section III (b) (i), HIV testing carries with it the risk that test results might be made available to others. The clearest risk comes during conditional or mandatory testing programs; after all, the very fact that the test is mandated suggests there is a strong interest in the test result. Blood and tissue donors are routinely screened for HIV infection; donors who test positive for HIV are placed on an indefinite deferral list

¹⁴⁰ This analytical framework is adapted from Mark A. Hall, Mary Anne Bobinski & David Orentlicher, *Health Care Law & Ethics* (New York: Aspen Publishing, 2007) at 180.

¹⁴¹ *R. v. Oakes*, [1986] S.C.J. No. 7, [1986] 1 S.C.R. 103, 26 D.L.R. (4th) 200 (S.C.C.).

¹⁴² *Ibid.*

to prevent use of their blood or tissue.¹⁴³ This use of HIV test results has not been particularly controversial; indeed the major dispute has involved how to improve the collection and use of information on a nationwide scale.¹⁴⁴

Post-exposure testing rules also inherently involve the disclosure of HIV-related information to third parties — it is, after all, the disclosure of the information to the person who might have been exposed to HIV which is the core justification for the testing itself. Yet post-exposure testing programs attempt to limit the intrusion on the privacy of the person who is forced to undergo testing. The Ontario *Mandatory Blood Testing Act*, for example, provides that the analyst of the sample should make reasonable efforts to deliver the results to the physician of the exposed person (the “applicant”) and, where requested, to the source individual’s (“respondent’s”) physician.¹⁴⁵ The statute prohibits the use of the test result or the disclosure of the test result for any other purpose.¹⁴⁶

These disclosure policies focus on the protection of the health and safety of third parties. A strong interest in protecting health and safety might justify the intrusion into individual privacy interests, but may the government require the disclosure of HIV-related information for other reasons, such as to improve the collection of data regarding the incidence and prevalence of HIV infection within a population? Which level of government should take responsibility for the collection and distribution of surveillance data? These issues were hidden in this chapter’s discussion of the collection of HIV/AIDS statistics in Section II (d), above.¹⁴⁷

The answer to these questions implicates two of the major strands of debate about HIV-related policies: finding the proper balance between individual liberty and public health objectives and struggling with whether HIV should be treated differently because of the social stigma associated with the disease. For HIV, the debate has gone through two stages. In the early days of the pandemic, Canadian and American jurisdictions made AIDS diagnoses reportable to public health authorities in a form which included the name or other identifiable information about the person

¹⁴³ See for example Canadian Blood Services, “Indefinite Deferrals”, online: <http://www.bloodservices.ca/CentreApps/Internet/UW_V502_MainEngine.nsf/page/Indefinite%20Deferral?OpenDocument>.

¹⁴⁴ See generally Library and Archives Canada, “Commission of Inquiry on the Blood System of Canada, Final Report” (1997) (“Krever Report”), online: Library and Archives Canada <http://epe.lac-bac.gc.ca/100/200/301/hcan-scan/commission_blood_final_rep-e/index.html>.

¹⁴⁵ *Mandatory Blood Testing Act, 2006*, S.O. 2006, c. 26, s. 5(2).

¹⁴⁶ *Ibid.*, ss. 7, 8.

¹⁴⁷ See generally UNAIDS, “The Role of Name-Based Notification in Public Health and HIV Surveillance” (2000) at 6-10 (brief history of disease reporting), online: UNAIDS <http://www.who.int/hiv/strategic/surveillance/en/unaid00_28e.pdf>; Lawrence O. Gostin, Scott Burris & Zita Lazzarini, “The Law and the Public’s Health: A Study of Infections Disease Law in the United States” (1999) 99 Colum. L. Rev. 59.

diagnosed.¹⁴⁸ Although this identifying information is collected at the state or provincial level, only the case report without identifying information is conveyed on to the national government in Canada and the United States.¹⁴⁹

The introduction of HIV antibody testing in 1985 created a new source of information about the prevalence and incidence of HIV infection, yet government authorities have faced considerable controversy in crafting policies regarding HIV reporting. For many public health officials, HIV reporting was a logical extension of existing policies on AIDS reporting.¹⁵⁰ For others and for advocates of civil liberties, the risks of HIV reporting outweighed the benefits. Critics of HIV reporting noted the long period during which persons with HIV infection could remain healthy and capable of working, the absence of effective treatments for the infection, the risk that HIV reporting might deter people from undergoing testing, and the injuries that could follow from breaches in

¹⁴⁸ In the United States, for example, all 50 states listed AIDS as a reportable diagnosis in the 1980s. See Dennis H. Osmond, "Epidemiology of HIV/AIDS in the United States" (March 2003) in Laurence Peiperl, Susa Coffey, Oliver Bacon, & Paul Volberding, *HIV InSite Knowledge Base* (online textbook from the UCSF Center for HIV Information), online: <<http://hivinsite.ucsf.edu/InSite?page=kb-00&doc=kb-02-01-01>>.

¹⁴⁹ See Canadian AIDS Society (CAS) and Health Canada, "A Guide to HIV/AIDS Epidemiology and Surveillance Terms" (2002) 6, 8 ("AIDS case report" & "notifiable disease"), online: Public Health Agency of Canada <http://www.phac-aspc.gc.ca/publicat/haest-tesvs/pdf/hiv_glossary_e.pdf>; UNAIDS, "The Role of Name-Based Notification in Public Health and HIV Surveillance" (2000), online: UNAIDS <http://www.who.int/hiv/strategic/surveillance/en/un aids_00_28e.pdf> at 6-11 (AIDS reporting more controversial in Canada than in the United States). National data collection is formally voluntary. See e.g., U.S. CDC, "CDC Guidelines for National Human Immunodeficiency Virus Case Surveillance, Including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome" (10 December 1999) 48 MMWR Recomm Rep. (RR13) 1 (detailing most recent surveillance guidelines and summarizing historical changes in diagnostic criteria); and Elaine Gibson, "Public Health Information, Federalism, and Politics" (2007) 16:1 Health L. Rev. 5 (arguing that federal government should increase collaboration with Provinces, and potentially consider legislation, to improve information-sharing about infectious diseases).

¹⁵⁰ UNAIDS, "The Role of Name-Based Notification in Public Health and HIV Surveillance" (2000), online: UNAIDS <http://www.who.int/hiv/strategic/surveillance/en/un aids_00_28e.pdf> at 12:

In the United States ... some public health officials ... made the claim that the very justification for AIDS reporting extended logically to HIV. Concerns about the accuracy of epidemiological surveillance and the capacity to intervene with infected individuals confirmed this view. Name reporting, advocates asserted, could alert public health agencies to the presence of individuals infected with a lethal virus; would permit such agencies to ensure that such persons were properly counseled; would permit those responsible for disease surveillance to better execute their tasks; would permit partner notification; and would permit officials to notify infected individuals when effective therapeutic agents became available.

confidentiality.¹⁵¹ As a result, many jurisdictions in the United States and Canada either did not require reporting of HIV test results or did not require reporting by name or unique identifier. This policy led to charges of HIV exceptionalism and to concerns that public health authorities were being denied access to information that could be important in policy responses to infection.

The balance began to shift as new antiretroviral treatments became available; these treatments reduced the incidence of AIDS diagnoses¹⁵² and also made it more likely that individuals would be motivated to seek out HIV testing as a precursor to treatment. The trend accelerated in 1999, when the U.S. CDC recommended that states establish HIV case surveillance systems modeled on those used for AIDS diagnoses, which included the name of the person testing positive for HIV.¹⁵³ All states in the U.S. were to move to nominal HIV reporting by the end of 2007.¹⁵⁴

The debate also unfolded in Canada during this time period with a steadily expanding number of provinces and territories requiring the reporting of HIV test results, most often by name, to a designated public health official. According to the Public Health Agency of Canada:

By 2003, positive HIV test results and AIDS diagnoses had been designated as notifiable in all Canadian provinces and territories. In most testing situations, laboratories and physicians are responsible for reporting HIV infection, but this varies by province or territory.

When HIV infection is notifiable, “nominal/name-based” or “non-nominal/non-identifying” information about an individual who tests positive for HIV infection is forwarded to provincial or territorial public health officials. This includes demographic data, such as the person’s age and gender; risks associated with the transmission of HIV; and laboratory data, such as the date of the person’s first positive HIV test.

¹⁵¹ See generally *ibid.*, at 12-13; Lawrence O. Gostin & James G. Hodge, Jr., “The ‘Names Debate’: The Case for National HIV Reporting in the United States” (1998) 61 Alb. L. Rev. 679.

¹⁵² The U.S. CDC noted the impact of this change: “With the advent of more effective therapy that slows the progression of HIV disease, AIDS surveillance data no longer reliably reflect trends in HIV transmission and do not accurately represent the need for prevention and care services.” U.S. CDC, “CDC Guidelines for National Human Immunodeficiency Virus Case Surveillance, Including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome” (10 December 1999) 48 MMWR Recomm Rep. (RR13) 1.

¹⁵³ *Ibid.* (“CDC has concluded that confidential name-based HIV/AIDS surveillance systems are most likely to meet the necessary performance standards ... as well as to serve the public health purposes for which surveillance data are required. Therefore, CDC advises that state and local surveillance programs use the same confidential name-based approach for HIV surveillance as is currently used for AIDS surveillance nationwide.”)

¹⁵⁴ Richard Pearshouse, “U.S.: All states to move to names-based HIV reporting in 2007” (2007) 12:1 Can. HIV/AIDS Pol’y & L. Rev. 37.

HIV infection is not legally notifiable at the national level, yet notification to PHAC is voluntarily undertaken by all provinces and territories. Positive HIV test reports and reported AIDS cases are provided non-nominally to PHAC.¹⁵⁵

Some provinces also continue to offer the option of anonymous HIV testing.¹⁵⁶ The end result is that Canada has retained a mixed system under which individuals in many provinces/territories retain access to non-nominal/non-identifiable testing programs. The availability of anonymous and non-identifiable testing probably is an important factor in encouraging members of at-risk groups to seek out HIV testing.¹⁵⁷

IV. STRATEGIES TO REDUCE TRANSMISSION

(a) Law and the Transmission of Disease

This chapter has been primarily concerned with the medical, social and legal aspects of identifying and tracking cases of HIV infection. The prevention of new cases of HIV transmission is undoubtedly at least an equally important objective. The remaining sections of this chapter will focus on whether and how the legal system should foster public health objectives by reducing the risk of HIV transmission. These sections will focus on three different sources of law: public health law, tort law and criminal law.

¹⁵⁵ Public Health Agency of Canada, "HIV/AIDS Epi Updates, November 2007" at 13. The report suggests but does not discuss the perennial dispute about whether public health data should be gathered at the provincial or federal level in Canada. Provincial public health legislation or regulations typically require reporting of certain identified communicable diseases by identified categories of persons (typically physicians and laboratories) to an identified provincial public health authority. See for example British Columbia Centre for Disease Control, "List of Reportable Communicable Diseases in BC" (April 2008), online: <<http://www.bccdc.org/content.php?item=7>>. Although public health primarily is a matter of provincial concern, the federal government also plays an important role in encouraging the collection and distribution of data on a nationwide basis. The SARS epidemic focused renewed attention on the need to create a national public health infrastructure. The new federal Public Health Agency of Canada is charged with a number of important tasks, including helping to coordinate data collection about communicable diseases such as HIV/AIDS. Public Health Agency of Canada, "HIV/AIDS Epi Updates, November 2007".

¹⁵⁶ *Ibid.*, at 14-15 (Table 1) (five provinces continue to offer anonymous testing; two offer anonymous testing but positive test results are reported nominally).

¹⁵⁷ *Ibid.*, at 14-15. But see James M. Tesoriero *et al.*, "The Effect of Name-Based Reporting and Partner Notification on HIV Testing in New York State" (2008) 98 Am. J. Public H. 728 (HIV testing rates in NY did not decline after adoption of nominal reporting and contact tracing; high-risk individuals not aware of law and few expressed concerns about policy).

(b) Traditional Public Health Law

(i) Introduction

The testing and reporting regimes described above provide an important foundation for the public health response by giving information about the existence and prevalence of a particular disease. Public health authorities use a wide range of strategies to reduce the risks associated with communicable diseases, including contact tracing and partner notification; mandatory treatment; vaccination; and isolation/quarantine.¹⁵⁸ Many of these strategies are simply inapplicable to the problem of HIV infection: there is (as yet) no treatment capable of eliminating the virus from an infected person,¹⁵⁹ no vaccine to prevent transmission, and the costs of isolation/quarantine would greatly outweigh the benefits given the long course of HIV infection and the relative difficulty of transmitting the virus. The debate about whether and how to employ traditional public health strategies to prevent infection has therefore focused on contact tracing and partner notification. This section will focus on whether and how to employ three specific public health strategies to prevent infection: post-exposure prophylaxis for sexual or needle-sharing incidents, contact tracing and public health orders.

(ii) Post-Exposure Prophylaxis after Sexual Activity or Injection Drug Use

Soon after the development of antiretroviral drug therapies, researchers began to explore whether the drugs could be used to reduce the risk of HIV transmission after an exposure incident.¹⁶⁰ The early focus was on occupational transmission in health care settings and public health authorities in the United States and Canada quickly developed and regularly updated protocols for post-exposure prophylaxis (“PEP”) in these settings.¹⁶¹ Studies indicated that PEP significantly reduced the risk

¹⁵⁸ See generally Lawrence O. Gostin, *Public Health Law: Power, Duty, Restraint* (Berkeley: University of California Press, 2008); Lawrence O. Gostin, Scott Burris & Zita Lazzarini, “The Law and the Public’s Health: A Study of Infectious Disease Law in The United States” (1999) 99 Colum. L. Rev. 59.

¹⁵⁹ Current therapies cannot “cure” HIV infection, but they can be applied to reduce the risk of HIV infection arising from an exposure incident. See *supra*, text accompanying notes 94–117.

¹⁶⁰ David K. Henderson & Julie L. Gerberding, “Prophylactic zidovudine after occupational exposure to the human immunodeficiency virus: an interim analysis” (1989) 160 J. Infect. Dis. 321.

¹⁶¹ See, e.g., “An Integrated Protocol to Manage Health Care Workers Exposed to Bloodborne Pathogens” (1997) 23:S2 CCDR 1 (Table 4 and Appendix), online: Public Health Agency of Canada <<http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/97vol23/23s2/index.html>>; Adelisa

of HIV transmission following needlestick and other percutaneous exposures in the health care settings.¹⁶² PEP was also considered and implemented for other types of occupational exposures, such as for police officers and firefighters, as well as for survivors of sexual assault.¹⁶³

Despite the efficacy of PEP, there was considerable controversy about whether PEP should be made available to persons who were exposed or potentially exposed to HIV through voluntary sexual activity or injection drug use.¹⁶⁴ The controversy included expressions of concern about whether moral judgments about certain types of behaviour might be colouring the public health response. Public health officials defended the delay in expanding nonoccupational PEP (“nPEP”), noting that nPEP’s effectiveness had not been demonstrated for other types of exposure incidents, that broadly available nPEP might indirectly encourage risky conduct, that antiretroviral drugs had significant side effects and expense, and that persons receiving nPEP might be a future source of drug-resistant virus in the community.¹⁶⁵

After several years of additional study and consultation, the U.S. Department of Health and Human Services found that these concerns did not outweigh the benefits of offering nPEP to persons with nonoccupational exposures.¹⁶⁶ Under the new recommendations, persons who present themselves within 72 hours after a sufficiently risky exposure

L. Panlilio *et al.*, “Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis” (2005) 54 MMWR Recomm Rep. (RR09) 1

¹⁶² See, *e.g.*, D.M. Cardo *et al.*, “A case-control study of HIV seroconversion in health care workers after percutaneous exposure” (1997) 337 N. Eng. J. Med. 1485 (ten-fold reduction in transmission rate).

¹⁶³ See, *e.g.*, Ellen R. Wiebe *et al.*, “Offering HIV Prophylaxis to People Who Have Been Sexually Assaulted: 16 Months’ Experience in a Sexual Assault Service” (2000) 162 C.M.A.J. 641 (study of Vancouver-based program; the first North American PEP program to be offered in a sexual assault service). Study results found low rates of PEP adherence and resulted in guideline revision to target highest risks of HIV infection (*ibid.*, at 641).

¹⁶⁴ Dawn K. Smith *et al.*, “Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States: Recommendations from the U.S. Department of Health and Human Services” 54 MMWR Recomm Rep (RR2) 1, 2 (citing history of consultation on the topic).

¹⁶⁵ *Ibid.*, at 2-5 (reporting results of research and consultation related to each of these concerns).

¹⁶⁶ *Ibid.*, at 12. See also, James O. Kahn *et al.*, “Feasibility of Postexposure Prophylaxis (PEP) against Human Immunodeficiency Virus Infection after Sexual or Injection Drug Use Exposure: The San Francisco PEP Study” (2001) 183 J. Inf. Dis. 707; Jeffrey N. Martin *et al.*, “Use of Postexposure Prophylaxis Against HIV Infection Following Sexual Exposure Does Not Lead to Increase in High-Risk Behavior” (2004) 18 AIDS 787; Mauro Schechter *et al.*, “Behavioral Impact, Acceptability, and HIV Incidence Among Homosexual Men With Access to Postexposure Chemoprophylaxis for HIV” (2004) 35 J. Acquir. Immune Defic. Syndr. 519.

incident with a known HIV-infected person should be given access to the therapy.¹⁶⁷ The guidelines do not recommend for or against nPEP where the exposure incident involves a person of unknown HIV status.¹⁶⁸ Finally, “[f]or persons whose exposure histories represent no substantial risk for HIV transmission or who seek care >72 hours after potential nonoccupational exposure, the use of antiretroviral nPEP is not recommended”.¹⁶⁹ The guidelines offer additional commentary on the use of nPEP for “vulnerable populations”, including inmates and injection drug users. The guidelines support the use of nPEP for both these groups, noting in particular that “injection-drug use should not deter clinicians from prescribing nPEP if the exposure provides an opportunity to reduce the risk for consequent HIV infection”.¹⁷⁰

Access to nPEP in Canada is somewhat more complex. There are no national guidelines affirming the appropriateness of nPEP. There is evidence of great variability in the availability of nPEP across Canada, with little or no access in some areas and limited access in others.¹⁷¹ Ironically, given Canada’s commitment to publicly funded health care, part of the difficulty with access may be financial: “In Britain, if a physician concludes treatment is necessary, the cost ... is covered by the National Health Service. For Canadians whose drug costs are not covered

¹⁶⁷ Dawn K. Smith *et al.*, “Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States: Recommendations from the U.S. Department of Health and Human Services” 54 MMWR Recomm Rep. (RR2) 1 at 8 (text and “Figure 1. Algorithm for evaluation and treatment of possible nonoccupational HIV exposures”). nPEP should be administered as soon as possible after exposure, ideally within hours, but not later than 72 hours after exposure to be effective, and must be continued for four weeks. The therapy can have debilitating side effects and that costs are not insignificant. *Ibid.*, at 8-11.

¹⁶⁸ *Ibid.*, at 9 (“Clinicians should evaluate the risk for and benefits of this intervention on a case-by-case basis”). The recommendations note the desirability of obtaining the source’s HIV status voluntarily, ideally through a rapid HIV test (*ibid.*).

¹⁶⁹ *Ibid.*

¹⁷⁰ *Ibid.*, at 15. The guidelines implicitly suggest that clinicians can take into account whether the exposure incident is “an exceptional occurrence” or part of ongoing conduct in determining whether nPEP is appropriate (*ibid.*). (“In judging whether exposures are isolated, episodic, or ongoing, clinicians should consider that persons who continue to engage in risk behaviors (*e.g.*, commercial sex workers or users of illicit drugs) might be practicing risk reduction ... Therefore a high risk exposure might represent an exceptional occurrence for such persons despite their ongoing risk behavior” (*ibid.*).

¹⁷¹ See, *e.g.*, Ann Silversides, “HIV Prophylaxis Expensive and Sometimes Difficult to Obtain” (2006) 175 C.M.A.J. 1360 (“the delivery of PEP for accidental sexual exposure has received the least policy attention”); and Canadian AIDS Treatment Information Exchange (CATIE), “PEP: Post-Exposure Prophylaxis (Treatment After Exposure to HIV)” (March 2005) (“Policy and practices of providing PEP may vary in different cities”), online: <http://www.catie.ca/acasfs_e.nsf/dfac88ab9edb2ab485256cc2006448f6/b2d401786c9de2b0852571b400638a4b!OpenDocument>.

by a public or private drug plan, the \$1000 to \$1500 price tag can be a major deterrent to treatment.”¹⁷²

There is evidence that provincial drug programs are unwilling to cover the costs of nPEP. British Columbia’s Centre for Excellence in HIV/AIDS offers extensive and detailed “Accidental Exposure Guidelines”, to “[provide] a framework for a program of expert advice and prompt anti-retroviral prophylaxis for accidental exposures in the health care setting and community”; however, the B.C. Centre’s guidelines note that “[t]his program does not provide coverage for events which arise in the individual’s personal life such as consensual adult sex or incidents arising in drug using environments”.¹⁷³ The B.C. Centre notes that “individuals who feel they have been exposed in these situations can purchase drugs”.¹⁷⁴

The gap in access to nPEP for Canadians is troubling. The medical and public health benefits of nPEP have been recognized by leading public health organizations, including the U.S. Department of Health and Human Services.¹⁷⁵ It is not clear why a medically beneficial treatment that also promotes public health objectives should be excluded from public coverage when other therapies related to the consequences of our “personal lives” remain publicly funded. The funding gap creates a

¹⁷² Silversides, *ibid.*, at 1360.

¹⁷³ British Columbia Centre for Excellence in HIV/AIDS, “Management of Accidental Exposure to HIV Guidelines” (as of September 2007), online: <<http://www.cfenet.ubc.ca/content.php?id=86>>.

¹⁷⁴ *Ibid.* The B.C. Centre notes that “a guideline for this eventuality [possible exposure through consensual adult sex or drug using environments] is available”, citing Dawn K. Smith *et al.*, “Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States: Recommendations from the U.S. Department of Health and Human Services” 54 MMWR Recomm Rep. (RR2) 1. This program’s position on nPEP is reinforced in another portion of its guidelines:

It is not the intention of this program to provide provincially funded drugs to persons exposed to HIV as part of their personal lives, *e.g.*, consensual adult sex or sharing injection equipment. The principles enunciated here may be applicable to some of those exposures, and the exposed person and their physician may choose to obtain the medications through another source.

Ibid., at 4. (Physicians considering nPEP are instructed to review the U.S. guidelines.) See also Ann Silversides, “HIV prophylaxis expensive and sometimes difficult to obtain” (2006) 175 C.M.A.J. 1360 (quoting a medical resident with two patients who had inquired about nPEP: “The [drug] cost would have been covered if I had a needle-stick [injury] ... it didn’t seem fair that they would have to pay. This seems to me to be an anomaly in the health care system”).

¹⁷⁵ Dawn K. Smith *et al.*, “Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States: Recommendations from the U.S. Department of Health and Human Services” 54 MMWR Recomm Rep. (RR2) 1. See also Martin Fisher *et al.*, UK Guideline for the Use of Post-Exposure Prophylaxis for HIV Following Sexual Exposure” (2006) 17 Int’l J. of STD & AIDS 81.

significant barrier to the use of a proven method of reducing HIV transmission.

The next issue beyond nPEP may well be “prEP”: pre-exposure prophylaxis, or using antiretroviral therapies before potential exposures to reduce the risk of transmission. Researchers are exploring whether pre-exposure use of antiretroviral therapies can reduce the risk of HIV transmission.¹⁷⁶ Some gay men in the United States reportedly have begun to use prEP.¹⁷⁷ Many of the same concerns about indirectly encouraging risky behaviour and the potential for drug resistant strains of HIV have been raised along with the obvious ethical, financial and practical challenges to providing pre-exposure antiretroviral access when many already infected with the virus around the world are unable to access treatment.¹⁷⁸

(iii) Contact Tracing and Partner Notification

The terms “contact tracing” and “partner notification” tend to be used interchangeably along with the broader concept of “partner counseling and referral services (PCRS)”.¹⁷⁹ Whatever term is issued, contact tracing has several benefits. Persons who have been exposed to the risk of HIV transmission are given vitally important information that allows them to seek testing and counseling about methods of reducing the risk of transmission in the future. Persons who discover they are infected have an opportunity to change their behaviour to prevent transmitting the virus to others and to seek early medical care.

¹⁷⁶ See, e.g., P. Denton *et al.*, “Antiretroviral Pre-Exposure Prophylaxis Prevents Vaginal Transmission of HIV-1 in Humanized BLT Mice” (2008) 15 PLoS Med. e13. See also, online: PrEP Watch <<http://www.prepwatch.org/trials.htm>>.

¹⁷⁷ Albert Liu *et al.*, “Limited Knowledge and Use of HIV Post- and Pre-Exposure Prophylaxis Among Gay and Bisexual Men” (2008) 47 JAIDS 241.

¹⁷⁸ See, e.g., Greg Szekeres & Thomas Coates, “Policy and Practice Implications of HIV Pre-Exposure Prophylaxis (PrEP) in the United States” (November 2006) (summarizing clinical trials, concerns, and recommendations), online: UCLA Program in Global Health <http://globalhealth.med.ucla.edu/publications/prep_nov06.pdf>. See also, Roxanne Nelson, “Study Reports Benefit of HIV Pre-Exposure Chemoprophylaxis” (2007) 7 Lancet Infect. Dis. 706; and Aranka Anema, Evan Wood & Julio S.G. Montaner, “The Use of Highly Active Retroviral Therapy to Reduce HIV Incidence at the Population Level” (2008) 179 C.M.A.J. 13 (focusing on impact of expanded access to antiretrovirals for persons with clinical indications rather than prEP).

¹⁷⁹ Matthew Hogben *et al.*, “The Effectiveness of HIV Partner Counseling and Referral Services in Increasing Identification of HIV-Positive Individuals” (2007) 33:2S Amer. J. Prev. Med. S89 (“Partner counseling and referral services (PCRS) comprise a range of services intended to support HIV-positive individuals and their partners in making health choices and receiving appropriate health care as well as to promote healthier communities by reducing the spread of HIV” at S89).

Contact tracing generally involves gathering information from a source individual (typically called the “index case”), who is infected with a communicable disease, about people (“contacts”) who might have been exposed to the illness.¹⁸⁰ Successful contact tracing requires the source individual’s cooperation in identifying contacts.¹⁸¹ For HIV infection, this process can include identifying sexual partners, needle-sharing partners, the recipients of blood or tissue donations, or others who might have been exposed to the blood or body fluids of the source individual under circumstances which could present the risk of infection. Occasionally, a health professional or public health official already knows the identity of possible contacts.¹⁸²

In traditional contact tracing programs, also termed “provider referral” programs, once the index case identifies one or more possible contacts, then public health authorities alert the contacts to the risk that they might have been exposed to the disease.¹⁸³ Contacts are counselled about the need to undergo testing and, if they test positive, are encouraged to disclose the identities of their contacts and to seek medical care.

The standard approach toward communicating with contacts includes safeguarding the identity of the source individual.¹⁸⁴ This protection might prove illusory, however, where a contact has only a few — or even one — possible sources of risk.¹⁸⁵ Contact tracing can be

¹⁸⁰ See generally Ralf Jürgens, “Partner Notification” in *“HIV Testing and Confidentiality: Final Report”* (2001), online: Canadian HIV/AIDS Legal Network <<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=282>>; Lawrence O. Gostin & James G. Hodge, “Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy and Disclosure in Partner Notification” (1998) 5 *Duke J. Gender L. & Pol’y* 9; William. E. Adams, Jr. *et al.*, *AIDS: Cases and Materials* (Durham: Carolina Academic Press, 2002) at 112-13.

¹⁸¹ But see *F. (I.) v. Peel (Region) Health Department*, 2006 WL 4752624 (Ont. H.S.A.R.B.), 2006 CarswellOnt 9249 (Dkt HP.7321) (public health authorities seek order requiring husband to disclose wife’s name for partner notification in case involving gonorrhoea).

¹⁸² The index case may be accompanied by a sexual or needle sharing partner, for example.

¹⁸³ See Canadian HIV/AIDS Legal Network, “Confidentiality” in *HIV Testing* (2007) (series of 12 information sheets on HIV testing in Canada), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=713>> at 2 (discussing types of partner notification). See also M. Golden *et al.*, “Support Among Persons Infected with HIV for Routine Health Department Contact for HIV Partner Notification” (1 February 2003) 32 *J. Acquir Immune Defic Syndr.* 196 (study suggests that a majority of persons with HIV infection favour health department-facilitated contact notification programs).

¹⁸⁴ Lawrence O. Gostin & James G. Hodge, “Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy and Disclosure in Partner Notification” (1998) 5 *Duke J. Gender L. & Pol’y* 9.

¹⁸⁵ A contact individual is likely to be able to identify a source individual when the contact has only had one sexual partner, no needle sharing partners, and no other possible sources of exposure. See also Timothy K.S. Christie & Perry R.W. Kendall, “The Science of Partner Notification: A Review of Available Evidence” (April 2003) 45 *B.C. Med. J.* 124, online:

intrusive or embarrassing for the source individual and may inadvertently result in the disclosure of the identity of the source individual.¹⁸⁶ The process can be labour intensive and expensive if carried out by public officials. Contact tracing techniques continue to evolve; new methods of contact tracing take into account the impact of the Internet on facilitating sexual encounters, for example, by using e-mail to make contact with otherwise anonymous sexual contacts.¹⁸⁷

Professors Gostin and Hodge identify two variations on traditional contact tracing programs.¹⁸⁸ One type of program relies on the index case to disclose the risk of infection to their contacts while public health officials provide support and reminders to the index case.¹⁸⁹ The second variation on traditional contact tracing programs is a “hybrid” approach, often called “conditional referral”.¹⁹⁰ These contact tracing programs combine aspects of the provider and patient referral strategies: index cases are to be told, for example, that the disclosure will be made by public health officials unless the index case makes the disclosure within a set time frame.¹⁹¹

In the early years of the HIV epidemic, there was considerable debate about whether and how contact tracing should be employed for

<<http://www.bcmj.org/science-partner-notification-review-available-evidence>>.

¹⁸⁶ See, e.g., *F. (I.) v. Peel (Region) Health Department*, 2006 WL 4752624 (Ont. H.S.A.R.B.), 2006 CarswellOnt 9249 (Drt. HP. 7321) (husband resists disclosing name of wife for purposes of partner notification in case involving gonorrhoea).

¹⁸⁷ Matthew J. Mimiaga *et al.*, “Acceptability of an Internet-Based Partner Notification System for Sexually Transmitted Infection Exposure Among Men Who Have Sex With Men” (2008) 98 *Amer. J. Public H.* 1009; U.S. CDC, “Using the Internet for Partner Notification of Sexually Transmitted Diseases — Los Angeles County, California, 2003” (20 February 2004) 53 *MMWR* 129.

¹⁸⁸ Lawrence O. Gostin & James G. Hodge, “Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy and Disclosure in Partner Notification” (1998) 5 *Duke J. Gender L. & Pol’y* 9. See also Canadian HIV/AIDS Legal Network, “Confidentiality” in *HIV Testing* (2007) (series of 12 information sheets on HIV testing in Canada), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=713>>; Janet S. St. Lawrence *et al.*, “STD Screening, Testing, Case Reporting, and Clinical and Partner Notification Practices: A National Survey of US Physicians” (2002) 92 *Amer. J. Public Health* 1784-88 (noting that most physicians relied on patients to follow up on partner notification on their own or with the health department).

¹⁸⁹ Gostin and Hodge express concerns that “[p]atient referral programs provide no assurance that contacts are notified, little control over the quality of the information conveyed, and no confidentiality protection for the identity of the index patient” (*ibid.*, at 26-27).

¹⁹⁰ *Ibid.*, at 27.

¹⁹¹ *Ibid.* See also A. Carballo-Diequez *et al.*, “Intention to Notify Sexual Partners about Potential HIV Exposure Among New York City STD Clinic’s Clients” (29 August 2002) 29 *Sex. Transm. Dis.* 465.

HIV infection.¹⁹² Proponents argued that this traditional public health strategy should be used to inform potential contacts about the risk of infection so they could undergo testing and modify their behaviour to reduce the risk of infection to others. Some suggested the failure to employ PCRS was a form of HIV exceptionalism that gave greater weight to individual privacy than to the preservation of life.¹⁹³ Opponents of contact tracing argued that the cost of contact tracing outweighed the benefits.¹⁹⁴ The U.S. CDC was an early and strong proponent of contact tracing in the United States yet implementation proved difficult.¹⁹⁵

¹⁹² See generally Lawrence O. Gostin & James G. Hodge, "Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy and Disclosure in Partner Notification" (1998) 5 Duke J. Gender L. & Pol'y 9 at 25-26; and Ralf Jürgens, "Partner Notification" in *HIV Testing and Confidentiality: Final Report* (2001), online: Canadian HIV/AIDS Legal Network <<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=282>>.

¹⁹³ See *New York State Society of Surgeons v. Axelrod*, 77 N.Y.2d 677 (1991) (medical organizations bring suit against Commissioner of Health in effort to force state government to include HIV on list of communicable diseases subject to contact tracing; state law subsequently amended).

¹⁹⁴ Lawrence O. Gostin & James G. Hodge, "Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy and Disclosure in Partner Notification" (1998) 5 Duke J. Gender L. & Pol'y 9 at 78. Recent studies suggest a favorable cost/benefit ratio. See, e.g., Matthew Hogben *et al.*, "The Effectiveness of HIV Partner Counseling and Referral Services in Increasing Identification of HIV-Positive Individuals" (2007) 33:2S Amer. J. Prev. Med. S89; Devon D. Brewer, "Case-Finding Effectiveness of Partner Notification and Cluster Investigation for Sexually Transmitted Diseases/HIV" (2005) Sexually Transmitted Diseases 78. Some jurisdictions have employed a modified approach which focuses scarce public health resources on finding contacts from "low risk groups" who might be thought to have less reason to be aware of the risk of exposure. See U.S. CDC, "Current Trends Partner Notification for Preventing Human Immunodeficiency Virus (HIV) Infection — Colorado, Idaho, South Carolina, Virginia" (1 July 1988) 37 MMWR 393. In the early days of the pandemic in the United States, this meant focusing on the heterosexual contacts of persons with HIV infection. The Royal Society of Canada adopted a similar analysis in the 1980s. Ralf Jürgens, "Partner Notification" in *HIV Testing and Confidentiality: Final Report* (2001), online: Canadian HIV/AIDS Legal Network <<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=282>>.

¹⁹⁵ U.S. CDC, "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV: Recommendations of the CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Disease Society of America" (18 July 2003) 52 MMWR Recomm Rep. (RR12) 1; U.S. CDC, *Technical Guidance for HIV/AIDS Surveillance Programs, Volume III: Security and Confidentiality Guideline* (2006) (Attachment G focuses on Using HIV Surveillance Data to Document Need and Initiate Referrals"), online: <<http://www.cdc.gov/hiv/surveillance.htm>>; M. Golden *et al.*, "Partner Notification for HIV and STD in the United States: low coverage for gonorrhoea, chlamydial infection, and HIV" (June 2003) 30 Sex. Transm. Dis. 490 (study suggests that barely over 50 per cent of persons testing positive for HIV in high prevalence areas of the U.S. have been interviewed for partner notification).

Contact tracing was rejected by influential groups in Canada early in the epidemic, but became an accepted part of public health practice in the 1990s.¹⁹⁶ In 1997, the Federal/Provincial/Territorial Advisory Committee on AIDS produced general guidelines on partner notification.¹⁹⁷ The Committee affirmed the utility of partner notification and established principles, such as confidentiality and voluntariness.¹⁹⁸ The guidelines suggest that the precise form of contact tracing program might vary from province to province based on a variety of factors.¹⁹⁹

The contact tracing programs developed across Canada were established through public health policy and professional guidelines, sometimes without any specific legislative action.²⁰⁰ In 2001, four provinces or territories required partner notification, legal authorities in three provinces appeared to permit contact tracing, and four provinces lacked any relevant legislation.²⁰¹ More provinces now have enacted or are considering specific legislative authorization for contact tracing as a part

¹⁹⁶ See generally UNAIDS, “The Role of Name-Based Notification in Public Health and HIV Surveillance” (2000), online: UNAIDS <http://www.who.int/hiv/strategic/surveillance/en/un aids_00_28e.pdf> at 36 (citing rejection of contact tracing in 1984 by the National Advisory Committee on AIDS); Public Health Agency of Canada, “Supplement: Point of Care HIV Testing Using Rapid HIV Test Kits: Guidance for Health-Care Professionals” (November 2007) 33:S2 CCDR 1, 10 (“HCPs are required ... to assist in contact tracing and counseling of the patient”); Public Health Agency of Canada, “HIV Testing and Counselling: Policies in Transition?” (2007) (research paper prepared for the International Public Health Dialogue on HIV Testing and Counseling, Toronto, 17 August 2006), online: <<http://www.phac-aspc.gc.ca/aids-sida/publication/hivtest/index-eng.php>> at 23, 63-64 (“Partner notification must be undertaken in all cases of AIDS and HIV infection. Local public health authorities are available to assist with partner notification and help with referral. The treating physician is responsible for ensuring that partner notification is initiated” at 23); Ralf Jürgens, “Partner Notification” in *HIV Testing and Confidentiality: Final Report* (2001), online: Canadian HIV/AIDS Legal Network <<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=282>>.

¹⁹⁷ Ralf Jürgens, “Partner Notification” in *HIV Testing and Confidentiality: Final Report* (2001), online: Canadian HIV/AIDS Legal Network <<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=282>>; Canadian HIV/AIDS Legal Network, “Confidentiality” in *HIV Testing* (2007) (series of 12 information sheets on HIV testing in Canada), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=713>> at 2-3.

¹⁹⁸ Ralf Jürgens, “Partner Notification” in *HIV Testing and Confidentiality: Final Report* (2001), online: Canadian HIV/AIDS Legal Network <<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=282>>.

¹⁹⁹ *Ibid.*

²⁰⁰ Ralf Jürgens, “Mandatory or Compulsory HIV Testing” in *HIV Testing and Confidentiality: Final Report* (2001), online: <<http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=282>> (“Legislation differs substantially from province to province, but these differences are often not reflected in the provinces’ partner notification practices”).

²⁰¹ *Ibid.* (citing Ontario, Saskatchewan, the Northwest Territories and Yukon as jurisdictions requiring partner notification; Prince Edward Island, New Brunswick and Alberta as authorizing contact tracing; and Newfoundland, Nova Scotia, Québec and British Columbia as failing to have applicable legislation).

of efforts to bolster public health preparedness for a wide range of infectious diseases such as SARS.²⁰² A range of partner notification options are offered to HIV infected persons, including patient, provider, and conditional referral.²⁰³ Contact tracing would now appear to have become a mainstream public health policy for HIV infection.

(iv) Public Health Orders

Most public health law and policy initiatives focused on HIV have stressed individual rights and voluntary cooperation rather than coercion. Yet the state's power to invade individual liberty where necessary to protect the public health is well established.²⁰⁴ When should public health authorities use coercion instead of persuasion to reduce the risk of HIV transmission?

There have been hints of the coercive powers of the provincial and federal governments in previous sections. Mandatory reporting requirements, post-exposure testing provisions, and orders requiring the disclosure of contact represent a few examples. The public health laws also provide authority for even more substantial restrictions on individual liberty designed to protect others from the risk of disease transmission. Public health officials may consider coercive measures when HIV-infected individuals who know their status and the risks continue to engage in conduct that places others at risk for infection.²⁰⁵

²⁰² See, e.g., Bill 23, B.C. *Public Health Act*, 2008, s. 29 (legislative proposal, third reading) (“a medical health officer may order a person to do one or more of the following: ... provide to the medical health officer or a specified person ... information respecting persons who may have been exposed to an infectious agent ... by the person”), online: B.C. Ministry of Health <<http://www.health.gov.bc.ca/phact/>>.

²⁰³ See for example P.R.W. Kendall, “Provincial Health Officer’s Report of HIV Reportability” (February 2002) at 22-24 (discussing options), online: Health Services <<http://www.healthservices.gov.bc.ca/pho/pdf/hivreportability.pdf>>; I. Rasooly *et al.*, “A survey of public health partner notification for sexually transmitted diseases in Canada” (July-August 1994) 85 *Can. J. Pub. Health* S48 (Supplement 1) (physicians often considered responsible for partner notification for HIV).

²⁰⁴ See generally, Lawrence O. Gostin, *Public Health Law: Power, Duty, Restraint* (Berkeley: University of California Press, 2008).

²⁰⁵ According to some researchers, “it appears clear that at least a substantial minority of people with HIV do not disclose their seropositivity to all of their sex partners.” O. Kenrik Duru *et al.*, “Correlates of Sex Without Serostatus Disclosure Among a National Probability Sample of HIV Patients” (2006) 10 *AIDS Behav.* 495. Researchers have focused on trying to understand more about the determinants of disclosure versus non-disclosure among HIV-infected individuals. See also Jeffrey T. Parsons *et al.*, “Consistent, Inconsistent, and Non-Disclosure to Casual Sexual Partners Among HIV-Seropositive Gay and Bisexual Men” (2005) 19:S1 *AIDS* S87; P.M. Gorbach *et al.*, “Don’t Ask, Don’t Tell: Patterns of HIV Disclosure Among HIV Positive Men Who Have Sex with Men with Recent STI Practicing High Risk Behavior in Los Angeles and Seattle” (2004) 80 *Sex.*

Many provinces and territories have specific legislation authorizing certain public health officials to issue orders restricting individual liberty to protect public health.²⁰⁶ Alberta's *Public Health Act* includes specific provisions giving certain public health authorities the power to issue orders compelling persons with HIV to refrain from engaging in conduct putting others at risk of transmission:

29(1) A medical officer of health who knows of or has reason to suspect the existence of a communicable disease . . . may initiate an investigation to determine whether any action is necessary to protect the public health.

(2) Where the investigation confirms the presence of a communicable disease, the medical officer of health . . .

(b) may . . .

(i) take whatever steps the medical officer of health considers necessary . . .

(B) to protect those who have not already been exposed to the disease,

(C) to break the chain of transmission and prevent spread of the disease, and

(D) to remove the source of infection;

(ii) by order

(C) prohibit a person from having contact with other persons or any class of persons

for any period and subject to any conditions that the medical officer of health considers appropriate, where the medical officer of health determines that the person's engaging in that activity could transmit an infectious agent²⁰⁷

Transm. Inf. 512; Daniel H. Ciccarone *et al.*, "Sex Without Disclosure of Positive HIV Serostatus in a US Probability Sample of Persons Receiving Medical Care for HIV Infection" (2003) 93 *Amer. J. Public H.* 949; Michael D. Stein *et al.*, "Sexual Ethics: Disclosure of HIV-Positive Status to Partners" (1998) 158 *Arch. Intern. Med.* 253; Robert Klitzman and Ronald Bayer, *Mortal Secrets: Truth and Lies in the Age of AIDS* (Baltimore, MD: John Hopkins University Press, 2003).

²⁰⁶ Canadian HIV/AIDS Legal Network, "Disclosure of HIV Status After Cuerrier: Resources for Community Based AIDS Organizations" (2004) at 5-1 to 5-34 online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=36>>; and Canadian HIV/AIDS Legal Network, "Public health laws and HIV prevention" in *Criminal Law and HIV* (2008 information sheets), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=847>>.

²⁰⁷ Under the *Communicable Diseases Regulation*, HIV-infected persons are prohibited from "engag[ing] in any activity that may transmit disease": *Alta. Reg.* 238/85, Sch. 4.

Alberta's *Public Health Act* also gives additional power to address "recalcitrant patients" with certain diseases such as HIV infection or AIDS.²⁰⁸

39(1) Where a physician, community health nurse, midwife or nurse practitioner knows or has reason to believe that a person

- (a) is infected with a disease prescribed in the regulations for the purposes of this section, and
- (b) refuses or neglects . . .

- (ii) to comply with any other conditions that have been prescribed by a physician as being necessary to mitigate the disease or limit its spread to others,

the physician, community health nurse, midwife or nurse practitioner shall immediately notify the medical officer of health in the prescribed form.

(2) Where the medical officer of health is satisfied as to the sufficiency of the evidence that the person may be infected, the medical officer of health shall issue a certificate in the prescribed form. . . .²⁰⁹

The "certificate" gives authority for peace officers to seize the recalcitrant patient for commitment in a facility and for a physician to make additional orders designed to prevent the transmission of disease.²¹⁰ Persons subject to a certificate can apply to the Court of Queen's Bench for the cancellation of the certificate.²¹¹ A patient can also be released if the physician certifies that he or she is satisfied that the patient will comply with any conditions necessary to protect public health.²¹²

In 2005, an expert working group convened by the Federal/Provincial/Territorial Advisory Committee on HIV/AIDS issued recommendations regarding the response to risky behaviour by HIV-infected persons.²¹³ The working group endorsed "a graduated response":

²⁰⁸ Alberta *Communicable Diseases Regulation*, Alta. Reg. 238/85, Sch. 3.

²⁰⁹ Alberta *Public Health Act*, R.S.A. 2000, c. P-37, s. 39.

²¹⁰ *Ibid.*, at s. 40. "(1) A certificate is authority (a) for any peace officer to apprehend the person named in it and convey the person to any facility specified by the medical officer of health within 7 days from the date the certificate is issued ... and (d) for a physician to prescribe any other conditions necessary to mitigate the disease or limit its spread to others.")

²¹¹ *Ibid.*, at s. 39. "(5) A person in respect of whom a certificate is issued may apply by originating notice to a judge of the Court of Queen's Bench at any time for cancellation of the certificate. ... (9) The judge may grant or refuse the order applied for and may make any other order the judge considers appropriate.")

²¹² *Ibid.*, at s. 41. The patient can be re-apprehended if he or she fails to adhere to these conditions: *ibid.*, at s. 43. An isolation order is also possible: *ibid.*, at ss. 44-46.

²¹³ "Persons Who Fail to Disclose Their HIV/AIDS Status: Conclusions Reached by an Expert Working Group" (2005) 31:5 CDR 53 (no author listed).

The first level focuses on counselling and education [which might include mandating that an infected person use protection during sexual activity]. The second level consists of assisting the HIV-positive person to access support services. The third level involves issuing public health orders to regulate the person's behaviour. The fourth level involves issuing apprehension and isolation orders under public health law, while the final level involves criminal prosecution.²¹⁴

The working group's recommendations were based in large part on a system of graduated intervention adopted by the Calgary Health Region under Alberta's public health legislation, described above.²¹⁵ The working group noted that "Due process and *Charter* rights must be respected in ... [coercive governmental interventions]. This includes advance notice of the intervention, the right to counsel, timely reviews of decisions rendered, the right to a fair hearing, and the right to appeal decisions."²¹⁶

Public health orders are often compared and contrasted with the use of criminal law, as discussed in Section IV (d).²¹⁷ Commentators generally suggest that the use of public health law is preferable to the use of criminal law, in part because of factors such as the ability to tailor the coercive intervention to the specific risk and the reduced stigma.²¹⁸ Ultimately, though, it is important to recognize that public health law orders can be enforced with some of the same sanctions found in criminal law, such as with fines or imprisonment.²¹⁹ In addition, unless carefully

²¹⁴ Glenn Betteridge, "Recommendations published concerning non-disclosure of HIV status" (2005) 10:2 Canadian HIV/AIDS Pol'y & L. Rev. 18, 18 (citing "Persons Who Fail to Disclose Their HIV/AIDS Status", *ibid.*, at 57-60).

²¹⁵ "Persons Who Fail to Disclose Their HIV/AIDS Status", *ibid.*, at 57-60.

²¹⁶ *Ibid.*, at 54. See also, Canadian HIV/AIDS Legal Network, "Public health laws and HIV prevention" in *Criminal Law and HIV* (2008 information sheets), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=847>>; and Nola M. Ries, "Legal Issues in Disease Outbreaks: Judicial Review of Public Health Powers" (2007) 16:1 Health L. Rev. 11.

²¹⁷ See, e.g., UNAIDS, "Criminal Law, Public Health and HIV Transmission: A Policy Options Paper" (2002) (authored by Richard Elliott), online: <http://data.unaids.org/publications/IRC-pub02/JC733-CriminalLaw_en.pdf>.

²¹⁸ See, e.g., *ibid.*, at 29 ("[i]n the very small number of cases where involuntary measures are reasonably and demonstrably essential, the use of carefully controlled involuntary public health measures is generally to be preferred over criminal sanction") (citing National Advisory Committee on AIDS, "HIV and Human Rights in Canada" (1992)).

²¹⁹ *Ibid.*, at 28. According to the UNAID report,

At the most coercive extreme, public health laws take on a quasi-criminal character. Health officials may have the power to compel examination and medical treatment of people suspected of being infected with a transmissible disease. They may also order an infected person to conduct themselves in such a manner as to avoid, or reduce the likelihood of, infecting others. An example would be an order prohibiting a HIV-positive person from having unprotected sex and/or ordering that person to disclose his or her HIV infection to sexual partners. Depending on the legislation in question, breaches of such public health orders could result in penalties such as fines

implemented, public health orders can result in perpetual restrictions on liberty.²²⁰ The next two sections turn to the use of tort and criminal law to address risky behaviour.

(c) Tort Liability

(i) Introduction

Tort law formally has several purposes, including establishing the standard of care expected in society, deterring wrongful conduct that deviates from this standard of care, and compensating persons injured by wrongful conduct. Tort law duties generally are established through individual cases brought by claimants seeking compensation for injuries allegedly caused by the wrongful conduct of the defendants. A finding of liability serves to compensate the plaintiff and to establish a deterrent for others engaging in similar behaviour. Tort law might therefore be an important source of a duty to protect others from HIV infection.

There are, however, two barriers to this use of tort law. First, it is not always clear whether and how to apply the basic elements of tort claims to problems involving HIV infection. Second, behind the formal structure and functions of tort law, reality is more complex. Many people are completely unaware of tort standards of conduct and tort duties probably do not really shape the behaviour of individuals as much as judges or lawyers might want. Moreover, tort claims are not likely to be brought against impecunious, uninsured defendants. This is likely to be a factor in the use of tort law to shape the behaviour of persons infected with HIV to the extent that HIV infection has disproportionately impacted socially and economically marginalized communities. Thus both the formal elements and informal realities of tort law have affected the types of HIV-related claims made in Canada.

or imprisonment; or such orders could be backed up by court orders, with similar penalties for breaching a court-issued order. Health officials also generally have the power to detain a person if this is demonstrably justified as necessary to prevent the transmission of disease (generally and preferably in a health-care setting, although again legislation and practice may vary across jurisdictions). The law may authorize the use of the state's police powers to enforce detention orders by public health officials.

Ibid. See also, Canadian HIV/AIDS Legal Network, "Public health laws and HIV prevention" in *Criminal Law and HIV* (2008 information sheets), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=847>>.

²²⁰ See, Canadian HIV/AIDS Legal Network, "Public health laws and HIV prevention" in *Criminal Law and HIV* (2008 information sheets), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=847>>; Isabel Grant, "The Boundaries of Criminal Law: The Criminalization of the Nondisclosure of HIV" (2008) Dal. L.J. (forthcoming) (manuscript on file with author).

This chapter will focus on four different types of potential HIV-related tort duties: the duty of blood banking organizations to protect recipients; the duty of HIV-infected health care providers to protect their patients from infection; the duty of an HIV-infected person to protect his or her sexual or needle sharing partners; and the duty of physicians or other professionals to warn third parties of the risk of infection.

(ii) Blood Banking Litigation

Blood and tissue banking organizations faced the spectre of tort liability in the early years of the epidemic after it became clear that AIDS could be transmitted by exposure to blood but before implementation of HIV-antibody screening tests in 1985.²²¹ Blood banking organizations struggled to protect the safety of the blood supply, using a range of methods including asking those believed to be at high risk of infection to refrain from donation.²²² They considered using surrogate testing and screening methods, keenly aware that these blunt instruments might cause unintended injuries by limiting the supply of blood. Once the HIV antibody test became available, officials had to determine whether and how to test past donations.²²³

The Commission of Inquiry on the Blood System of Canada conducted an extensive investigation of the blood system's response to HIV, issuing a three-volume final report in 1997.²²⁴ The Report, commonly referred to as the Krever Report after the Commissioner of the Inquiry, criticizes many of the choices made by persons involved in securing the blood supply from the risks of HIV and other diseases. Indeed, the Commission's activity generated litigation reaching the Supreme Court of Canada on the authority of a Commission of Inquiry to publish statements that might be misconstrued as findings of criminal or civil liability.²²⁵ Blood banking organizations and others have been found

²²¹ The connection to blood was drawn relatively early in the pandemic by the high rates of disease among hemophiliacs.

²²² For more background on the history of HIV and the blood supply, see E. Feldman & Ronald Bayer, *Blood Feuds: AIDS, Blood, and the Politics of Medical Disaster* (New York: Oxford University Press, 1999); Lauren B. Leveton, Harold C. Sox, Jr. & Michael A. Stoto, *HIV and the Blood Supply: An Analysis of Crisis Decisionmaking* (Washington, D.C.: National Academies Press, 1995), online: The National Academic Press <<http://www.nap.edu/catalog/4989.html>>.

²²³ See for example *Canadian AIDS Society v. Ontario*, [1996] O.J. No. 4184, 31 O.R. (3d) 798 (Ont. C.A.), leave to appeal to S.C.C. refused [1997] S.C.C.A. No. 33 (S.C.C.).

²²⁴ See generally Library and Archives Canada, "Commission of Inquiry on the Blood System of Canada, Final Report" (1997) ("Krever Report"), online: Library and Archives Canada <http://epe.lac-bac.gc.ca/100/200/301/hcan-scan/commission_blood_final_rep-e/index.html>.

²²⁵ *Canada (Attorney General) v. Canada (Commission of Inquiry on the Blood System-Krever Commission)*, [1997] S.C.J. No. 83, [1997] 3 S.C.R. 400 (S.C.C.), Cory J. [*Canada*

liable for failing to exercise due care and for failing to warn individuals of the risk of infection.²²⁶ In *Walker Estate v. York-Finch General Hospital*, the Supreme Court of Canada found that the defendants were negligent in the manner in which they screened donors to reduce the risk of HIV before the implementation of HIV testing.²²⁷

(iii) *HIV-Infected Health Care Providers*

HIV infection can be transmitted by exposure to blood or other infected body fluids. These fluids are common in health care settings and health care providers have adopted the use of “universal precautions” to minimize the risk of exposure for health care providers and patients.²²⁸ Because of lapses or failures in the use of universal precautions, the provision of some types of health care involving persons with HIV infection may involve very small risks.

There are a few cases of documented HIV transmission from HIV-infected patients to health care providers, but the risk of transmission is considered to be quite low.²²⁹ Patients generally do not have a tort duty to inform their health care provider of their infection. Furthermore, HIV infection is considered to be a protected disability in Canada and health

(*Attorney General*) cited to S.C.R.]. The Court held that the Commission did not have the authority to establish civil or criminal liability but found that it had not exceeded its authority; in addition, the Commission had provided adequate procedural and notice protections for the complainants.

²²⁶ See for example *Pittman Estate v. Bain*, [1994] O.J. No. 463, 112 D.L.R. (4th) 257 (Ont. Gen. Div.). Blood banking organizations and other defendants have also been found to have observed the standard of care and therefore shielded from liability. See for example Collin Smith & Grant Holly, “Court strikes out latest action in contaminated blood litigation” (December 2003) 8 Can. HIV/AIDS Pol’y and L. Rev. 1 at 56 (citing *Robb v. St. Joseph’s Health Centre; Rintoul v. St. Joseph’s Health Centre; Farrow v. Canadian Red Cross Society*, [2001] O.J. No. 4605 (Ont. C.A.), leave to appeal to S.C.C. refused [2002] S.C.C.A. No. 44 (S.C.C.)).

²²⁷ *Walker Estate v. York-Finch General Hospital*, [2001] S.C.J. No. 24, [2001] 1 S.C.R. 647, 198 D.L.R. (4th) 193 (S.C.C.).

²²⁸ Health Canada, “Preventing the Transmission of Bloodborne Pathogens in Health Care and Public Service Settings” (May 1997) 23:S3 CCDR 1, online: Public Health Agency of Canada <<http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/97pdf/cdr23s3e.pdf>>.

²²⁹ See, e.g., B. Stringer, C. Infante-Rivard & J. Hanley, “Quantifying and Reducing the Risk of Bloodborne Pathogen Exposure” (2001) 73 AORN J. 1142; Theodore de Bruyn, “Occupational Exposure to HIV and Forced HIV Testing: Questions and Answers”, online: Canadian HIV/AIDS Legal Network, <<http://www.aidslaw.ca/publications/publications/docEN.php?ref=278>>; Canadian AIDS Society, “Position Statement, Occupational Exposure, June 2007” (risk of HIV transmission following needlestick injury approximately 0.3 per cent; two probable and one definite case of HIV transmission from patients to providers in Canada), online: Canadian AIDS Society <[http://www.cdn aids.ca/web/setup.nsf/ActiveFiles/Occupational+Exposure+colour/\\$file/Occupational%20Exposure%20colour.pdf](http://www.cdn aids.ca/web/setup.nsf/ActiveFiles/Occupational+Exposure+colour/$file/Occupational%20Exposure%20colour.pdf)>.

care providers therefore are prohibited from discriminating against HIV-infected patients.²³⁰

Although the level of risk is similar, the rights and duties of HIV-infected health care providers have been more controversial.²³¹ Should HIV-infected health care providers be permitted to continue to treat patients? If they do, should they be required to disclose their status to patients so that patients can knowingly agree or refuse to accept the admittedly very small risks?

There is little regulation and no reported litigation involving the duties of HIV-infected health care providers in Canada. The Québec College of Physicians recommends that physicians know their HIV status and that HIV-infected physicians consult with their employers before performing certain types of medical procedures.²³² The policy does not require an infected provider to disclose his or her status to patients.²³³

It is not clear whether HIV-infected physicians must disclose their HIV status to their patients under tort or fiduciary principles.²³⁴ The

²³⁰ Theodore de Bruyn, "A Plan of Action for Canada to Reduce HIV/AIDS-Related Stigma and Discrimination" (2004) at 15-19 (summarizing anti-discrimination regulatory framework). Discrimination against patients persists. See, e.g., Brad Sears & Deborah Ho, "HIV Discrimination in Health Care Services in Los Angeles County: The Results of Three Testing Studies" (reporting that 46 per cent of skilled nursing facilities, 26 per cent of plastic surgeons, and 55 per cent of obstetricians surveyed refused services to HIV-infected patients), online: Williams Institute at UCLA, <<http://www.law.ucla.edu/williamsinstitute/publications/Discrimination%20in%20Health%20Care%20LA%20County.pdf>>.

²³¹ See, e.g., Mary Anne Bobinski, "Patients and Providers in the Courts: Fractures in the Americans with Disabilities Act" (1998) 61 Alb. L. Rev. 785 (noting issue of physician disclosure under U.S. law); Mary Anne Bobinski, "Autonomy and Privacy: Protecting Patients from Their Physicians" (1994) 51 U. Pitt. L. Rev. 291 (analyzing disclosure obligations under U.S. law).

²³² Collège des Médecins du Québec, "Le Médecin et les Infections Transmissibles par le Sang" (2004), online: Collège des Médecins du Québec <http://www.cmq.org/DocumentLibrary/UploadedContents/CmsDocuments/Position_infections_transmissibles_sang.pdf>.

²³³ *Ibid.* The policy is similar to that adopted by the U.S. CDC, "Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures" (12 July 1991) 40 MMWR Recomm Rep. (RR8) 1, in that affected physicians who perform procedures presenting a risk of infection must be evaluated by an expert review panel to determine whether and how they may continue to practice.

²³⁴ *McInerney v. MacDonald*, [1992] S.C.J. No. 57 at para. 20, [1992] 2 S.C.R. 138, 93 D.L.R. (4th) 415 (S.C.C.), *per* LaForest J. See also, Mary Anne Bobinski, "Patients and Providers in the Courts: Fractures in the Americans with Disabilities Act" (1998) 61 Alb. L. Rev. 785; Mary Anne Bobinski, "Autonomy and Privacy: Protecting Patients from Their Physicians", (1994) 51 U. Pitt. L. Rev. 291. See also U.S. CDC, "Recommendations for Preventing Transmission of Human Immunodeficiency Virus", *ibid.* ("HCWs [health care workers] who are infected with HIV... should not perform exposure-prone procedures unless they have sought counsel from an expert review panel and been advised under what circumstances, if any, they may continue to perform these procedures ... Such circumstances

Québec College of Physicians policy and a similar approach adopted by the U.S. CDC both suggest that HIV-infected health care providers may pose a significant risk to patients during some “exposure prone” medical procedures.²³⁵ A court might take the view that traditional informed consent rules or fiduciary principles require that infected health care workers seeking to perform these procedures inform their patients of the significant risks.²³⁶

On the other hand, the Alberta Court of Queen’s Bench decision in *Halkyard Estate v. Mathew* suggests that the HIV-infected physician does not have a duty to disclose this information to patients. In *Halkyard*, the court considered a claim that a surgeon with epilepsy had a duty to disclose his condition to his patient as a “material risk” under the informed consent process.²³⁷ The court rejected the claim, finding that any issues about the ability of the defendant to continue to practice should be dealt with by his medical providers and the hospital in which he practiced rather than through the doctrine of informed consent. The Court of Appeal, in affirming the judgment, noted that the result might have been different if the plaintiff had been able to demonstrate harm caused by the failure to disclose. It is not clear how this would apply in the case of an HIV-infected health care worker. Presumably a patient who could prove that he or she acquired HIV from his or her health care provider during an exposure-prone procedure might be able to bring an informed consent claim. What should be the result if the patient learns of the possible risk after a procedure and suffers anxiety and repeated HIV testing as a result without ever becoming infected?²³⁸

would include notifying prospective patients of the HCW’s seropositivity before they undergo exposure-prone invasive procedures”).

²³⁵ For discussion of other provincial policies and approaches, see Tyler Oswald, “Healthcare Workers Infected with Bloodborne Illnesses in Canada” (2007) 10:4 *Healthcare Quarterly* 64.

²³⁶ See *supra*, note 234; Canadian HIV/AIDS Legal Network, “Criminalization of HIV exposure: current Canadian law” at 2, in *Criminal Law and HIV* (2008 information sheets), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=847>>.

²³⁷ *Halkyard Estate v. Mathew*, [1998] A.J. No. 986, [1999] 5 W.W.R. 643 (Alta. Q.B.) [“*Halkyard Estate* (Q.B.)” cited to A.J.]; aff’d [2001] A.J. No. 293, 2001 ABCA 67 (Alta. C.A.) [“*Halkyard Estate* (C.A.)” cited to A.J.].

²³⁸ *Halkyard Estate* (Q.B.), *ibid.*, at paras. 6-19. The case may have turned on the absence of evidence linking the failure to disclose with the death of the patient. The Court of Appeal, in affirming the judgment, noted that “[w]hen harm is caused by the lack of disclosure, liability in negligence may arise”: *Halkyard Estate* (C.A.), *ibid.*, at para. 11. A patient might learn of the risk during a “look back” investigation conducted by a health institution that discovers that one of its health care workers was infected with HIV. See, e.g., U.K. Dep’t of Health, “HIV Infected Health Care Workers: Guidance on Management and Patient Notification” (2005) online: <http://www.advisorybodies.doh.gov.uk/eaga/pdfs/hiv_workers_280705.pdf>. The issues raised by “fears of HIV” claims are considered *supra*, text accompanying notes 256-64.

(iv) Tort Duties and Sexual Partners

What about the use of tort rules to promote safer behaviour by those who are or might be infected with HIV? Do persons diagnosed with HIV infection or those who are at risk for infection have a duty to refrain from conduct that could put others at risk? Should it be sufficient to inform others of the risk of infection? This section will focus on tort litigation involving sexual partners and the patients of HIV-infected health care providers.

Courts in the United States have considered claims brought under tort theories such as assault and battery; misrepresentation, fraud and deceit; and negligence.²³⁹ Although there are few references in reported case law, some Canadian commentators believe our courts will impose tort damages where an infected person fails to disclose his or her status to a potential sexual or needle sharing partner.²⁴⁰ The Supreme Court of Canada's decisions in two HIV-related criminal law cases, to be discussed below, might lend support to the application of tort law.

(v) Physicians and the Duty to Warn Third Parties

Health care providers who breach the standard of care in failing to protect patients from HIV infection, such as through failing to order appropriate testing or perinatal prophylactic treatment to prevent HIV transmission, can be held liable in tort.²⁴¹ Physicians who know or should know of a patient's HIV infection clearly have a duty to inform an infected patient and can be held liable for the reasonably foreseeable

²³⁹ Deanna A. Pollard, "Sex Torts" (2007) 91 Minn. L. Rev. 769; Gregory G. Sarno, "Tort Liability for Infliction of Venereal Disease" (1985-2008) 40 A.L.R. (4th) 1089. Plaintiffs in the United States generally prefer negligence-based claims because intentional torts are often excluded from coverage under homeowners and other insurance policies.

²⁴⁰ Nicolas Bala, "Tort Remedies and the Family Law Practitioner" (March 1999) 16 Can. Fam. L.Q. 423 (internal citations omitted):

The Supreme Court of Canada has indicated that a person who knows, or should reasonably know, that he or she has AIDS or another sexually transmitted disease may be liable in negligence to a partner who is not warned of the risk of infection and contracts the disease. This principle could be used to impose liability on an unfaithful spouse who negligently or knowingly infects his or her spouse as a result of a sexually transmitted disease.

See also Neo J. Tuytel, "Sexual Misconduct Claims: A Primer for Insurers on Liability and Coverage Issues Involving Sexual Assault, Abuse and Harassment (Part I)" (1998) 16 Can. J. Ins. L. 61 (focusing on sexual misconduct cases rather than disease transmission cases).

²⁴¹ See, e.g., *M. (G.) v. Alter*, [2006] O.J. No. 2762, 2006 WL 1903331, 2006 CarswellOnt 4190 (Ont. S.C.J.) (discussing settlement dispute in case arising from physician's alleged failure to offer appropriate HIV testing and treatment to prevent transmission to pregnant woman, whose child was infected with HIV).

consequences of failing to do so.²⁴² Assume that a physician has correctly diagnosed a patient's HIV infection and has informed the patient of his or her status and the necessary precautions to avoid further transmission of the disease. Does the physician have any further duties?

Studies demonstrate that a significant percentage of HIV-infected persons will continue to engage in behaviour that presents a risk to others without disclosing their status.²⁴³ Some commentators and litigants argue that physicians should have an additional duty to warn third parties when the health professional knows that an HIV-infected person is placing others at risk for infection. The proposed duty is controversial for several reasons.²⁴⁴ First, the duty may conflict with the physician's duty to maintain patients' confidences. Second, it is not always clear what actions will meet the duty — must a physician contact the third party directly or will a notice to public health authorities or other officials suffice? Third, the proposed rules are often fairly vague in establishing the scope of third parties (typically called “identifiable victims”) subject to protection. Finally, the doctrine is controversial because it imposes a duty on physicians to a third party who is not the physician's patient.

The duty to warn is most famously associated with the California Supreme Court's decision in *Tarasoff v. University of California Regents*.²⁴⁵ In *Tarasoff*, the court found that psychiatrists could be held liable to non-patients for “failing to exercise reasonable care to protect a third party where the therapists know or should know that their patient presents a serious danger of violence” to the third party, non-patient.²⁴⁶ The case provides a somewhat unstable foundation upon which to build a duty to warn third parties, given that it has been rejected or limited in many jurisdictions in the United States.²⁴⁷ Other American cases more clearly focus on a physician's duty to breach patient confidentiality when

²⁴² See, e.g., *Healey v. Lakeridge Health Corp.*, [2006] O.J. No. 4277, 2006 CarswellOnt 6574 (Ont. S.C.J.) (physician who fails to diagnose patient's TB might be held liable to third parties infected by the patient); and *Pittman Estate v. Bain*, [1994] O.J. No. 463, 112 D.L.R. (4th) 257 (Ont. Gen. Div.) (husband infected wife with HIV before being informed of his infection).

²⁴³ See note 205 at 3.

²⁴⁴ Canadian HIV/AIDS Legal Network, “Confidentiality” in *HIV Testing* (2007) (series of 12 information sheets on HIV testing in Canada), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=713>>. See also Mark A. Hall, Mary Anne Bobinski & David Orentlicher, *Health Care Law & Ethics* (New York: Aspen Publishing, 2007) at 185-98.

²⁴⁵ *Tarasoff v. University of California Regents*, 551 P.2d 334 (Cal. S.C. 1976).

²⁴⁶ See e.g., Mark A. Hall, Mary Anne Bobinski & David Orentlicher, *Health Care Law & Ethics* (New York: Aspen Publishing, 2007) at 185-98.

²⁴⁷ *Ibid.*

the patient has a contagious disease that poses a threat to identifiable third parties.²⁴⁸

Physicians in many Canadian provinces or territories have either the legal duty or the permissive authority to warn third parties:

[A]t least six provinces or territories (Alberta, Manitoba, Saskatchewan, Ontario, Prince Edward Island and the Yukon) have legislation that requires or permits physicians to disclose confidential information without a patient's consent if there are reasonable grounds to believe that this will avoid or minimize danger to another person. Where such statutes do not exist, health professionals must be guided by any other relevant legislation that governs medical confidentiality, court decisions regarding confidentiality and its limits, and professional codes or guidelines.²⁴⁹

One commentator has suggested that physicians in Canadian jurisdictions without specific legislation authorizing or requiring disclosure should refrain from making disclosures to protect third parties.²⁵⁰

There is a significant difference between being "required" or "permitted" to disclose otherwise confidential patient information. Canadian courts have not yet directly confronted the question of whether there is a common law duty to disclose a patient's HIV status to protect third parties.²⁵¹ The legal duty might be drawn from professional and ethical guidelines. In 1998, Ontario's Medical Expert Panel on Duty to Inform adopted a consensus statement that explicitly recommended a duty to warn third parties "when a patient threatens to cause serious harm to another person or persons and it is more likely than not the threat will be

²⁴⁸ *Ibid.*, at 192-93; Tracey A. Bateman, "Liability of Doctor or Other Health Practitioner to Third Party Contracting Contagious Disease from Doctor's Patient" (1993-2008) 3 A.L.R. (5th) 370.

²⁴⁹ Canadian HIV/AIDS Legal Network, "Confidentiality" in *HIV Testing* (2007) (series of 12 information sheets on HIV testing in Canada), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=713>> at 3. See also M. Carey, "The Limits of Doctor-Patient Confidentiality in Canada" (1998) 19 Health L. Can. 52, 1998 C.H.L. Lexis 24 at 26-28. Carey cites as one example a case involving liability for a failure to disclose syphilis to the known partner of someone when both parties were patients (citing *C. v. D.*, [1924] O.J. No. 113, 56 O.L.R. 209 (Ont. H.C.J.)); and *supra*, Section III (c) (i) of this chapter (discussing common law and statutory exceptions).

²⁵⁰ Donald G. Casswell, "Disclosure by a Physician of AIDS-Related Patient Information: An Ethical and Legal Dilemma" (1989) The Can. B. Rev. 225.

²⁵¹ In *Pittman Estate v. Bain*, [1994] O.J. No. 463, 112 D.L.R. (4th) 257 (Ont. Gen. Div.) the court did not reach the issue of whether the physician had a duty to disclose the patient's risk for HIV to his wife because liability could be predicated on the fact that the physician had not informed the patient of the risk: *Pittman Estate v. Bain*, *ibid.* ("It was unnecessary to determine whether an independent duty was owed to KP's wife, because there was a duty to inform KP himself, and, on the evidence, if KP had been told, he would certainly have alerted his wife.")

carried out".²⁵² However, the Ontario panel's recommendations conflict with the privacy code adopted by the Canadian Medical Association during the same time period. The CMA code focuses strongly on the need to preserve confidentiality and limits disclosures to those required by law or court order.²⁵³ The law in this area continues to remain unclear as there are no reported Canadian cases finding a health care professional liable for breaching a duty to warn in a case involving HIV.²⁵⁴

Even where courts have recognized tort-based obligations to prevent harm, plaintiffs face substantial obstacles in proving injury and causation. Where a plaintiff has HIV infection, it is often difficult to prove that the defendant was the source of the infection. The litigation can involve potentially embarrassing testimony about possible alternative sources of infection.²⁵⁵

²⁵² Lorraine E. Ferris *et al.*, "Defining the Physician's Duty to Warn: Consensus Statement of Ontario's Medical Expert Panel on Duty to Inform" (2 June 1998) 158 C.M.A.J. 1473. See also Christopher Zinn, "Wife Wins Case Against GPs Who did not Disclose Husband's HIV Status" (2003) 326 BMJ 1286 (reporting on US\$473,400 award to woman under negligence and breach of contract theories; GPs had told man she was about to marry of his positive test result but "fail[ed] to ensure that . . . [he] told his wife about the result").

²⁵³ Canadian Medical Association, *Health Information Privacy Code*, online: <http://www.cma.ca/index.cfm/ci_id/3216/la_id/1.htm#prin5>. See also John Hoey, "The CMA's Health Information Privacy Code: Does it Go Too Far?" (1998) 159 C.M.A.J. 953, 954 (noting possible conflict); and Canadian HIV/AIDS Legal Network, "Confidentiality" in *HIV Testing* (2007) (series of 12 information sheets on HIV testing in Canada), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=713>> at 3.

²⁵⁴ *Ibid.*, at 3.

²⁵⁵ See, *e.g.*, *supra* note 18 (discussing use of HIV testing to identify common sources of infection); and *John B. v. Superior Court*, 38 Cal.4th 1177, 137 P.3d 153 (Cal. Sup. Ct. 2006). In *John B.*, the California Supreme Court weighted the competing interests and permitted discovery of sensitive personal information in case involving possible HIV transmission from husband to wife:

Here, defendant has invoked his constitutional right to privacy as justification for refusing to answer questions concerning his HIV status or his sexual history. Bridget, in turn, has identified not only ... [the state's interest in truthful fact-finding in legal proceedings], but also the state's compelling interest in preventing the spread of AIDS, a communicable and dangerous disease ... [Various provisions in the criminal code] ... are strong statements by the Legislature that the spread of HIV is a serious public health threat and that its control is of paramount importance. ...

In balancing these competing concerns, we note at the outset that. ... [b]oth parties have admitted they are HIV positive, informally and in court filings. John thus has a diminished privacy interest in his HIV status. ... Moreover, not only does the complaint allege sufficient facts to permit the inference that John infected Bridget with HIV, but John has alleged that Bridget infected him. By thus putting his own medical condition at issue, John has "substantially lowered" his expectation of privacy even further. ... After balancing the competing interests in this case, we are persuaded that Bridget is entitled to discovery concerning John's sexual history and HIV status.

Ibid., 38 Cal.4th at 1199, 137 P.3d at 167 (citations omitted).

In many cases, plaintiffs are not able to demonstrate they have acquired HIV infection. In these cases, plaintiffs have sought to recover for the fear of acquiring HIV. These HIV phobia cases can be problematic, given the difficulty of drawing a line between compensable mental anguish and non-compensable, irrational fear.²⁵⁶ In *Garner v. Blue & White Taxi Co-operative Ltd.*, for example, a passenger sustained a needle-stick from a syringe while sitting in a cab.²⁵⁷ The court found the defendant was not liable for the injury because the cab driver had observed the required standard of care.²⁵⁸ The court nonetheless considered the plaintiff's damage claims. The court noted that although the passenger repeatedly tested negative for HIV infection and was told "that there was a 99 percent chance that he had not contracted HIV virus as of ... [a date] six months after the accident ... [he] continued to be fearful".²⁵⁹ The court found that the plaintiff suffered this anxiety for three years and assessed the proper damage for suffering at \$5,000.²⁶⁰

Most U.S. courts that have considered the issue attempt to limit HIV phobia claims to circumstances which involved a real risk of transmission (called "actual exposure") and to the time period during which a reasonable person might suffer from the fear of infection.²⁶¹ In *Fitzgerald v. Tin*, the British Columbia trial court considered and rejected this trend in another case involving a needle-stick injury to a passenger in a taxicab.²⁶² The court held:

I am satisfied that the "Possible Exposure" approach should be adopted in Canada. Until it can be shown with reasonable certainty that a plaintiff is not HIV positive, that plaintiff suffers the mental anguish of having a reasonable fear that they have become HIV positive. It was not

²⁵⁶ These cases also raise interesting procedural questions about the appropriate statute of limitations period: see, e.g., *Birrell v. Providence Health Care Society*, [2008] B.C.J. No. 53, 2008 BCCA 14, 73 B.C.L.R. (4th) 223, 2008 CarswellBC 41 (B.C.C.A.) (granting leave to appeal on question whether statute of limitations should begin to run from the time notice given of possible exposure); and the appropriate range of damages in cases where no disease has been transmitted: see, e.g., *Rideout v. Health Labrador Corp.*, [2007] N.J. No. 292, 2007 NLTD 150, 2007 CarswellNfld 268 (N.L.T.D.) (reviewing proposed settlement including adequacy of awards to plaintiffs who received notice that they might have been exposed to HIV and other diseases due to failure to sterilize equipment in gynecological clinic).

²⁵⁷ *Garner v. Blue & White Taxi Co-operative Ltd.*, [1995] O.J. No. 2636 (Ont. Gen. Div.).

²⁵⁸ *Ibid.*, at paras. 22-25.

²⁵⁹ *Ibid.*, at para. 29.

²⁶⁰ *Ibid.* The damages were not awarded because of the determination that the defendant was not liable.

²⁶¹ See Kimberly C. Simmons, "Recovery for Emotional Distress Based on Fear of Contracting HIV or AIDS" (1998-2003) 59 A.L.R. (5th) 535; *Shumosky v. Lutheran Welfare Services of Northeastern PA, Inc.*, 784 A.2d 196 (Pa. Super. 2001) (collecting cases; noting majority use actual exposure rule).

²⁶² *Fitzgerald v. Tin*, [2003] B.C.J. No. 203, 11 B.C.L.R. (4th) 375 (B.C.S.C.).

unreasonable for Ms. Fitzgerald to fear HIV infection after being exposed to a syringe. A syringe is clearly a medically viable channel of transmission of the HIV virus. The applicable standard of care requires that a person such as Ms. Fitzgerald conduct her life as if she had been actually exposed to HIV-positive fluids until such time as a blood test reveals ... that she is not HIV positive.²⁶³

Fitzgerald tested negative at seven months; the court awarded \$15,000 in damages for her mental distress during this time period.²⁶⁴

This brief overview of the relation between tort law and the risk of HIV transmission suggests that tort has been relatively underutilized to establish norms of conduct in Canada compared to the United States. This may reflect a general aversion to establishing standards of care via litigation or the relative paucity of damages available to tort claimants in Canada. In any event, it does not appear that tort liability has been constrained by charges of HIV exceptionalism.

(d) Criminal Law

As noted above, a small but significant percentage of HIV-infected persons continue to engage in conduct that could present a risk of transmission to others. There are ranges of behaviours and risks. Some HIV-infected persons always disclose their status and/or engage in safer practices while some do so much of the time; a very small percentage of persons with HIV infection actively seek to transmit the virus to others.²⁶⁵ The general category of “risky behaviour” includes a wide range of actual risks, for the probability of HIV transmission depends on factors such as the type of activity (from low to higher risk sexual or needle sharing activities), the “role” of the HIV-infected person (as a man or woman,

²⁶³ *Ibid.*, at para. 50.

²⁶⁴ *Ibid.*, at paras. 50-52 and Conclusion. Michael P. Busch & Glen A. Salten, “Time Course of Viremia and Antibody Seroconversion Following Human Immunodeficiency Virus Exposure” (1997) 102 *Am. J. Med. Supp.* 2 177. About 95 per cent of persons infected with HIV will produce antibodies to the virus within six months of exposure if they have been infected with the virus. Testing directly for the presence of the virus could reduce the time period of reasonable anxiety significantly. See *supra*, note 15.

²⁶⁵ Dennis H. Osmond *et al.*, “Changes in Prevalence of HIV Infection and Sexual Risk Behavior in Men Who Have Sex with Men in San Francisco: 1997-2002” (2007) 97 *Amer. J. Pub. H.* 1677 (noting increase in sexually risky activities); David A. Moskowitz & Michael E. Roloff, “The Existence of a Bug Chasing Subculture” (2007) 9 *Culture, Health & Sexuality* 347 (documenting existence of “bug chasers”: persons seeking to become HIV-infected); Christian Grov & Jeffrey T. Parsons, “Bug Chasing and Gift Giving: The Potential for HIV Transmission Among Barebackers on the Internet” (2006) 18 *AIDS Educ. & Prev.* 490 (“bug chasing” and “gift giving” exist in “barebacking” culture (men who seek unprotected anal sex) but the percentage of men actively seeking to transmit or to receive HIV is small).

participating in “receptive” or “penetrative” sexual activities of different types), the HIV-infected person’s viral load and the presence or absence of skin irritations or abrasions.²⁶⁶

Criminal law generally is used to deter and to punish wrongful conduct. As an instrument of public health policy, criminal law standards constitute society’s strongest statement regarding morally blameworthy conduct. The use of criminal law to address the risks of HIV transmission raises difficult legal issues and policy questions. How well does the criminal law framework respond to the complexities of risky activities and intentions noted above? Does the use of criminal law further the goal of protecting public health?

Criminal prosecutions have been quite common in the United States, particularly for members of the Armed Forces who are governed by the Military Code of Justice.²⁶⁷ Defendants have been convicted of HIV-related criminal offences for conduct ranging from spitting on another person to repeated sexual acts. Prosecutors have been successful in using traditional criminal offences ranging from attempted murder to assault with a deadly weapon. Many states also have specific laws making it a criminal offence to expose others to the risk of HIV transmission.²⁶⁸ Ironically, this type of HIV exceptionalism has frustrated some prosecutors, who argue they were able to invoke more substantial criminal penalties using traditional general offences such as attempted murder.²⁶⁹

In Canada, prosecutions for HIV-infected persons who place others at risk seem increasingly common and the sanctions seem increasingly severe.²⁷⁰ Canadian prosecutions are based on one or more of several theories: common nuisance;²⁷¹ criminal negligence;²⁷² and assault,²⁷³ including

²⁶⁶ Scott Burris *et al.*, “Do Criminal Laws Influence HIV Risk Behavior? An Empirical Trial” (2007) 39 *Ariz. St. L. J.* 467, 476-77.

²⁶⁷ See generally, Alan Stephens, “Annotation, Transmission or Risk of Transmission of Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) as Basis for Prosecution or Sentencing in Criminal or Military Case” (1993-2008) 13 *A.L.R.* (5th) 628.

²⁶⁸ *Ibid.*; Michael L. Clozen *et al.*, “Criminalization of an Epidemic: HIV-AIDS and Criminal Transmission Laws” (1994) 46 *Ark. L. Rev.* 921-83 (annotated panel discussion).

²⁶⁹ Clozen *et al.*, “Criminalization of an Epidemic”, *ibid.*

²⁷⁰ Canadian HIV/AIDS Legal Network, “Prosecutions under the *Criminal Code*” in *Criminal Law and HIV* (2008 information sheets), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=847>>; Isabel Grant, “The Boundaries of Criminal Law: The Criminalization of the Nondisclosure of HIV” (2008) *Dal. L.J.* (forthcoming).

²⁷¹ Under the *Criminal Code*, R.S.C. 1985, c. C-46, provisions on common nuisance:

180. (1) Every one who commits a common nuisance and thereby
 - (a) endangers the lives, safety or health of the public, or
 - (b) causes physical injury to any person, is guilty of an indictable offence and liable to imprisonment for a term not exceeding two years.
- (2) For the purposes of this section, every one commits a common nuisance who does an unlawful act or fails to discharge a legal duty and thereby

aggravated assault,²⁷⁴ and sexual assault.²⁷⁵ The key criminal prosecutions under assault involve questions about the interpretation of the *Criminal Code* provisions regarding consent.²⁷⁶ The consent issue first made its way up to the Supreme Court of Canada in *R. v. Cuerrier*.²⁷⁷

- (a) endangers the lives, safety, health, property or comfort of the public; or
 (b) obstructs the public in the exercise or enjoyment of any right that is common to all the subjects of Her Majesty in Canada.

The provision has been applied to the knowing donation of HIV-infected blood without disclosure of HIV status, *R. v. Thornton*, [1991] O.J. No. 25, 3 C.R. (4th) 381 (Ont. C.A.), aff'd [1993] S.C.J. No. 62, [1993] 2 S.C.R. 445 (S.C.C.), as well as to sexual activity by an HIV-infected person, *R. v. Williams*, [2003] S.C.J. No. 41, [2003] 2 S.C.R. 134 at para. 71, 230 D.L.R. (4th) 39 (S.C.C.) ["*Williams* (S.C.C.)" cited to S.C.R.]; *R. v. Williams*, [2004] N.J. No. 140, 2004 NLCA 24 at para. 5, 184 C.C.C. (3d) 193 (N.L.C.A.) ["*Williams* (C.A.)" cited to NLCA] (sentencing).

²⁷² Under the *Criminal Code*, *ibid.*, provisions governing criminal negligence:

219. (1) Every one is criminally negligent who (a) in doing anything, or (b) in omitting to do anything that it is his duty to do, shows wanton or reckless disregard for the lives or safety of other persons.

(2) For the purposes of this section, "duty" means a duty imposed by law

²⁷³ The *Criminal Code*, *ibid.*, defines general assault in s. 265:

265. (1) A person commits an assault when (a) without the consent of another person, he applies force intentionally to that other person, directly or indirectly . . .

(2) This section applies to all forms of assault, including sexual assault, sexual assault with a weapon, threats to a third party or causing bodily harm and aggravated sexual assault.

(3) For the purposes of this section, no consent is obtained where the complainant submits or does not resist by reason of . . . (c) fraud. . .

²⁷⁴ Under s. 268 of the *Criminal Code*, *ibid.*: "(1) Every one commits an aggravated assault who wounds, maims, disfigures or endangers the life of the complainant."

²⁷⁵ Aggravated sexual assault is defined in s. 273 of the *Criminal Code*, *ibid.*: "(1) Every one commits an aggravated sexual assault who, in committing a sexual assault, wounds, maims, disfigures or endangers the life of the complainant."

²⁷⁶ Under s. 273.1 of the *Criminal Code*, *ibid.*:

273.1 (1) Subject to subsection (2) and subsection 265(3), "consent" means, for the purposes of section [] ... 273, the voluntary agreement of the complainant to engage in the sexual activity in question.

(2) No consent is obtained, for the purposes of section [] 273, where ... (b) the complainant is incapable of consenting to the activity; (c) the accused induces the complainant to engage in the activity by abusing a position of trust, power or authority ...

(3) Nothing in subsection (2) shall be construed as limiting the circumstances in which no consent is obtained.

273.2 It is not a defence to a charge under section ... 273 that the accused believed that the complainant consented to the activity that forms the subject-matter of the charge, where (a) the accused's belief arose from the accused's ... (ii) recklessness or willful blindness; or (b) the accused did not take reasonable steps, in the circumstances known to the accused at the time, to ascertain that the complainant was consenting.

²⁷⁷ [1998] S.C.J. No. 64, [1998] 2 S.C.R. 371, 162 D.L.R. (4th) 513 (S.C.C.). Justice Cory delivered the judgment joined by Justices Major, Bastarache and Binnie. Justice

In *Cuerrier*, the defendant was instructed by a public health nurse to “use condoms every time he engaged in sexual intercourse and to inform all prospective sexual partners that he was HIV-positive”.²⁷⁸ The defendant had unprotected sex with two complainants without informing them of his status.²⁷⁹ *Cuerrier* “was charged with two counts of aggravated assault”.²⁸⁰ Neither complainant tested HIV positive at the time of trial.²⁸¹ Trial court entered a verdict of acquittal which was upheld by the Court of Appeal.²⁸² The Supreme Court allowed the appeal and ordered a new trial.

The Court found that *Cuerrier* had endangered the lives of the complainants.²⁸³ The remaining issue involved the consent provision of the statute. Justice Cory, writing for the majority, found that it was “no longer necessary when examining whether consent in assault or sexual assault cases was vitiated by fraud to consider whether the fraud related to the nature and quality of the act”.²⁸⁴ “[T]raditional requirements for fraud, namely dishonesty and deprivation” would also suffice to vitiate consent.²⁸⁵ According to the judgment, “[t]he actions of the accused must be assessed objectively to determine whether a reasonable person would find them to be dishonest” through deceit or non-disclosure.²⁸⁶ Deprivation could be shown either by “actual harm or simply a risk of harm” so long as the dishonesty “had the effect of exposing the person consenting to a significant risk of serious bodily harm”.²⁸⁷ In addition, “the Crown will still be required to prove beyond a reasonable doubt that the complainant would have refused to engage in unprotected sex with the accused” if she had knowledge of his HIV status.²⁸⁸

L’Heureux-Dubé wrote separately. Justice McLachlin submitted reasons with Gonthier J. joining.

²⁷⁸ *Ibid.*, at para. 78.

²⁷⁹ *Ibid.*, at paras. 79-82.

²⁸⁰ *Ibid.*, at para. 83.

²⁸¹ *Ibid.*

²⁸² *Ibid.*

²⁸³ *Criminal Code*, R.S.C. 1985, c. C-46, s. 273.

²⁸⁴ *R. v. Cuerrier*, [1998] S.C.J. No. 64 at para. 108, [1998] 2 S.C.R. 371, 162 D.L.R. (4th) 513 (S.C.C.).

²⁸⁵ *Ibid.*, at para. 125.

²⁸⁶ *Ibid.*, at para. 126.

²⁸⁷ *Ibid.*, at para. 128.

²⁸⁸ *R. v. Cuerrier*, [1998] S.C.J. No. 64 at para. 130, [1998] 2 S.C.R. 371, 162 D.L.R. (4th) 513 (S.C.C.). Madam Justice L’Heureux-Dubé would have adopted a more expansive view of fraud, permitting dishonesty to vitiate consent to sexual activity whenever the dishonesty was about a matter important enough to affect consent (*ibid.*, at para. 16). Madam Justice McLachlin would have adopted a narrower understanding of the fraud provision, limiting fraud to cases where “there was (a) a deception as to the sexual character of the act; (b) deception as to the identity of the perpetrator; or (c) deception as to the presence of a sexually transmitted disease giving rise to a serious risk or probability of infecting the complainant” (*ibid.*, at para. 70).

The interveners in *Cuerrier* argued that criminalization of HIV exposure was unnecessary because other public health measures already were available to address the conduct of HIV infected persons and because the risk of criminal liability might deter some individuals from undergoing testing.²⁸⁹ Justice Cory firmly rejected these arguments, expressing skepticism about the effectiveness of other public health law measures and noting that people were likely to undergo HIV testing because it was in their best interest to get treatment.²⁹⁰

The Supreme Court of Canada revisited the issue of criminal liability for persons with HIV infection in *R. v. Williams*.²⁹¹ In *Williams*, the accused discovered that he was HIV-infected and then continued to have sexual relations with the complainant without telling her of his infection.²⁹² The problem for the Crown was that there was no proof as to when the complainant acquired HIV infection. She might have been infected by Williams before he was aware of his HIV status. Justice Binnie, writing for the majority, found that the accused could not be convicted of aggravated assault because of the lack of proof that he had endangered the complainant's life after he knew that he had HIV.²⁹³ The accused was properly convicted of attempted aggravated assault and common nuisance.²⁹⁴

The Supreme Court's rulings in *Williams* and *Currier* confirmed the validity of the criminal law approach in Canada. Courts are continuing to

²⁸⁹ *Ibid.*, at paras. 140-46. See *supra*, Section IV (b) (iv) (public health orders).

²⁹⁰ *R. v. Cuerrier*, [1998] S.C.J. No. 64 at paras. 140-46, [1998] 2 S.C.R. 371, 162 D.L.R. (4th) 573.

²⁹¹ [2003] S.C.J. No. 41, [2003] 2 S.C.R. 134 (S.C.C.).

²⁹² *Ibid.*, at paras. 3-10.

²⁹³ *Ibid.*, at paras. 25, 46. Justice Binnie notes that criminal liability could apply even to cases in which the defendant was never officially informed of his or her HIV status:

The critical date for the purpose of establishing fraud to vitiate consent (*Criminal Code*, s. 265(3)(c)) is when the respondent had sufficient awareness of his HIV-positive status that he can be said to have acted "intentionally or recklessly, with knowledge of the facts constituting the offence, or with willful blindness toward them" (*R. v. Sault Ste. Marie (City)*, [1978] 2 S.C.R. 1299 (S.C.C.), at p. 1309) . . . Once an individual becomes aware of a risk that he or she has contracted HIV, and hence that his or her partner's consent has become an issue, but nevertheless persists in unprotected sex that creates a risk of further HIV transmission without disclosure to his or her partner, recklessness is established (*ibid.*, at paras. 27-28).

²⁹⁴ *Ibid.*, at paras. 60-66 (affirming conviction for attempted aggravated assault; noting *mens rea* and more than preparatory step toward *actus reus*); *R. v. Williams*, [2004] N.J. No. 140, 2004 NLCA 24 at para. 73, 184 C.C.C. (3d) 193 (N.L.C.A.) (conviction for common nuisance affirmed). Professor Isabel Grant notes that the Court's reasoning in *Williams* leads to the ironic result that prosecutors will find it easier to prosecute defendants for aggravated assault when the defendants' sexual contacts remain uninfected: Isabel Grant, "The Boundaries of Criminal Law: The Criminalization of the Nondisclosure of HIV" (2008) Dal. L.J. (forthcoming).

work through the implications of the criminal law approach in different areas. For example, Binnie J.'s suggestion in *Williams* that a defendant could not use willful ignorance of his or her HIV status as a defence has reduced concerns that criminal liability would simply encourage people to refuse testing. Yet questions remain about when a defendant will be deemed to have sufficient knowledge of the risk of HIV infection to be subject to the duty to disclose.²⁹⁵ Should previous participation in high risk activities be sufficient to impose a duty to warn? What about the degree of endangerment to life necessary for an assault conviction: how should this be mapped against the broad range of risks for different types of activities? Should a defendant's use of safer sex or needle-sharing practices or low viral load be sufficient to avoid criminal liability, at least for assault? What if an HIV-infected person informs a sexual contact of his or her status immediately after a sexual encounter and urges the contact to obtain post-exposure prophylaxis in order to greatly reduce any risk of harm?²⁹⁶ The answers are unclear.²⁹⁷ Finally, how should the criminal law respond to the admittedly rare problem of "bug chasing"? Should a person who knowingly transmits HIV to a willing recipient be held criminally responsible for murder or assisted suicide?

From a policy perspective, the trend toward the greater use of criminal law in Canada and elsewhere runs counter to substantial and growing concerns about whether the approach is misguided and perhaps even counterproductive to public health goals. A recent empirical study found that the behaviours and beliefs of HIV-infected people about

²⁹⁵ Canadian HIV/AIDS Legal Network, "Criminalization of HIV exposure: current Canadian law"; Isabel Grant, "The Boundaries of Criminal Law: The Criminalization of the Nondisclosure of HIV" (2008) Dal. L.J. (forthcoming).

²⁹⁶ See C. Dodds, "Positive Benefits: Preventive Impact of Post-Exposure Prophylaxis Awareness Among Those Diagnosed with HIV" (2007) 84 Sex. Transm. Infect. 92 (significant percentage of sample of men seeking post-exposure prophylaxis learned that a sexual partner was HIV positive following sexual contact). This example raises a potential conflict between criminal law and public health objectives. While pre-sexual activity disclosure of status might be preferred, even a post-exposure disclosure can give a sexual contact information that could be used to secure treatment and to avoid transmission. The optimal criminal law rule might therefore be to take an immediate post-exposure disclosure into account in reducing the severity of the offense or punishment.

²⁹⁷ Compare *R. v. Edwards*, [2001] N.S.J. No. 221, 2001 NSSC 80 (N.S.S.C.) (safer sex practices might reduce risk of harm below point justifying criminal liability) with *R. v. Mabior*, [2008] M.J. No. 277 at paras. 99-117 (Man. Q.B.) (endangerment of life proven even where condom used but broken during act, where protections used and when viral load low). See also, Canadian HIV/AIDS Legal Network, "Criminalization of HIV exposure: current Canadian law" in *Criminal Law and HIV* (2008 information sheets), online: <<http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=847>> at 1-2 ("the law is unclear about whether a person living with HIV has a duty to disclose his or her status when engaging in other sexual acts with a lower risk of HIV transmission than unprotected anal or vaginal sex").

disclosure or sexual activity were unrelated to the nature of the criminal law rules in their particular jurisdiction.²⁹⁸ Some critics argue that criminal sanctions can injure public health if the spectre of criminal liability discourages people from undergoing HIV testing. In addition, criminal liability standards might have unintended consequences if responsibility for protecting against HIV infection is distributed unevenly across society, such as when it is placed on people with HIV infection and not on those who believe they are uninfected. These concerns are echoed in a UNAIDS policy brief issued in 2008:

There are no data indicating that the broad application of criminal law to HIV transmission will achieve either criminal justice or prevent HIV transmission. Rather, such application risks undermining public health and human rights. Because of these concerns, UNAIDS urges governments to limit criminalization to cases of intentional transmission, *i.e.*, where a person knows his or her HIV positive status, acts with the intention to transmit HIV and does in fact transmit it.²⁹⁹

It remains to be seen whether Canada, or indeed any country, will step back from the use of criminal law in response to these recommendations.

V. LESSONS FOR THE FUTURE

It is commonplace to note that many citizens and health care providers in the 1980s were quaintly confident about medicine's inevitable triumph over infectious diseases. The recognition of widespread illness and the discovery of the HIV virus was the first of many tests to this confidence. The virus's unique characteristics made plotting a response difficult for health care providers, public health officials, policy-makers, and judges. The course of the HIV pandemic over the past 28 years sparked the re-examination of long neglected aspects of public health policy and law.

This chapter's treatment of the public health law aspects of HIV infection highlighted two major areas: (1) the public health aspects of case identification; and (2) the role of the legal system in addressing the risk of transmission. Although the legal response to HIV infection has been diverse and complex, three major thematic debates emerged: (1) What level(s) of government should be involved in the protection of public health? (2) Should HIV's unique characteristics inspire exceptional legal

²⁹⁸ Scott Burris *et al.*, "Do Criminal Laws Influence HIV Risk Behavior? An Empirical Trial" (2007) 39 *Ariz. St. L.J.* 467. See also Scott Burris & Edwin Cameron, "The Case Against Criminalization of HIV Transmission" (2008) 300 *JAMA* 578 (setting out the "case against criminalization").

²⁹⁹ UNAIDS, "Policy Brief: Criminalization of HIV Transmission" (2008), online: <http://data.unaids.org/pub/BaseDocument/2008/20080731_jc1513_policy_criminalization_en.pdf>.

strategies or should the response to HIV be “mainstreamed” into public health law and practice? and (3) What is the proper balance between the protection of individual liberties and the promotion of public health and safety?

Canada’s approach to the problems presented by HIV infection has largely been consistent with international norms and evolving public health norms. Jurisdictional issues — always present in a federal system of government — have resulted from time to time in complex overlapping systems of regulation. Canada’s approach to protecting privacy and preserving the confidentiality of medical information is one example of this difficulty. The impact of the still relatively new Public Health Agency of Canada on HIV policies remains to be seen.³⁰⁰

Canada has adopted many public health strategies that are informed by experience with HIV but has tended to avoid HIV exceptionalism. Unlike the United States, Canada never adopted special HIV testing and confidentiality statutes or HIV-specific criminal statutes. Canadian jurisdictions instead tended to incorporate the special concerns arising from the social stigma and discrimination associated with HIV into the pre-existing legal framework for informed consent, confidentiality, public health measures, and criminal law. In many areas, this mainstreaming of HIV issues appears to have succeeded in both promoting public health and protecting individual liberty. Criminal law is an important exception, given the increasingly frequent use of the relatively blunt instrument of criminal law to address the complex and nuanced questions of risk in sexual and needlesharing activity.

Finally, Canada has an excellent record of developing public health policies that incorporate the protection of individual liberty as a fundamental component of public health rather than an opposing goal. Yet Canada’s focus on individual rights arguably is fading. The emergence of moderately effective therapies to prolong life for persons infected with HIV appears to have played major role in changing this dynamic. Given the availability of life-extending treatment, people with HIV infection may now be motivated to seek testing and treatment even without continued focus on individual rights. The whittling away of the “three C’s” approach to HIV testing in favour of “routine” testing may be an important example of this phenomenon.

³⁰⁰ New policies on HIV testing expected to be released by PHAC in 2008 may provide an important signal.

