# PUBLIC HEALTH LEGISLATION AND HIV/AIDS: CONFRONTATIONS IN COMPULSORY CASE-REPORTING

by

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#### ABSTRACT

The question of how public health powers can and should be used to contain the spread of communicable disease is one that is now fraught with controversy as a result of the HIV/AIDS epidemic. The response to this epidemic in Canada and elsewhere has been typified by the implementation of traditional public health measures, with little apparent consideration of whether these measures are both an appropriate and desirable response to the problem.

This study looks at the historical development and constitutional foundation of the use of public health powers and examines existing HIV/AIDS case-reporting requirements in Canada, comparing them with those in three other countries with similar patterns of HIV infection, the United States, Australia and the United Kingdom. It is argued that these case-reporting requirements are inappropriate in many respects for achieving the desired public health objectives of case-reporting, and may even hinder those objectives. This points to the need for a re-evaluation of whether, and if so, how this form of public health intervention can and shr 11d be used in the context of HIV/AIDS.

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#### RESUME

Le SIDA suscite une vive controverse sur la nature et l'étendue des compétences dont dispose la Sante Publique pour enrayer la propagation des maladies contagieuses. Au Canada comme ailleurs, les autorités ont essentiellement recours aux mesures épidemiologiques traditionnelles, sans, semble-t-il, s'intérroger sur la pertinence et la caractere souhaitable de ces dernières.

Nous brosserons en premier lieu un tableau de l'évolution historiques et des bases constitutionnelles des pouvoirs des instances publiques dans la domaine de la santé, pour examiner ensuite les divers aspects au Canada de l'obligation de déclarer les cas de SIDA/VIH. Nous effectuerons une comparaison avec la practique en la matière aux Etats-Unis, en Australia et au Royaume-Uni, trois pays où l'épidémie accuse un développement similaire.

Nous nous efforcerons d'établir que la déclaration obligatoire est à plus d'un titre mal adapté aux objectifs poursuivis par la Santé Publique, et risque même d'entraver la réalisation de ceux-ci. Nous conclurons enfin qu'il convient de remettre en question les modalités, voire l'adoption pur et simple, de cette obligation dans le contexte du combat contre l'épidémie du SIDA.

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## I. INTRODUCTION

Until recently, one might have been forgiven for thinking that questions about the legitimate function of public health law were no longer of pressing importance. During the course of the twentieth century, once-fatal contagious diseases such as cholera, typhoid and smallpox had been either eradicated or controlled by advances in medical science. Other traditional public health concerns such as sanitation could no longer be regarded as controversial; to a large extent, we had achieved consensus as to the minimum acceptable standards and as to the need for public health authorities to enforce those standards. The role of public health authorities had come to be seen as largely administrative and divorced from any critical policy considerations.

AIDS of course has challenged this. It has challenged our complacency about the ability of modern medicine to conquer infectious disease. It has challenged our perceptions of individual and social responsibility. And on a very fundamental level, it has forced us to question the extent to which we are prepared to allow state intervention

in the interests of perceived communal health needs. Does the undisputed need to prevent the spread of HIV conflict with the equally compelling concerns for individual rights and social justice, and if so, how are we to reconcile these?

This question is at the heart of the debate about the use of public health powers, a debate which - in a bitter irony - has been injected with new life as a result of the AIDS epidemic. Perhaps predictably, traditional public health measures such as compulsory testing, case-reporting and quarantine have been proposed as an appropriate response to HIV/AIDS. But in the 1980's, such measures are not to be accepted without question. Just as our society has changed since the last great epidemics of infectious disease, so too must our collective response to threats or perceived threats to public health. A re-evaluation of the way in which public health powers can and should be used in this context has come to be of critical importance.

Unfortunately, the panic engendered by the AIDS epidemic and the resulting political imperatives have not produced the most favourable climate for an informed and well-considered assessment of the role that public health law can play in preventing the spread of HIV. In some jurisdictions, governmental action has been implemented in

haste, based on outdated public health legislation that was drafted in very different social conditions and with very different models of infectious disease in mind. Other jurisdictions have amended existing public health laws to include provisions directed specifically at HIV/AIDS, often with anomalous (and in some cases unintended) consequences. And in all but a few cases, there seems to have been little debate about the values which inevitably underpin public health policy and which are expressed in the way that we, as a society, respond to the disease.

The aim of this study is to consider the role that public health legislation - and in particular, compulsory case-reporting provisions - can play in containing the spread of HIV/AIDS. The issue of compulsory case-reporting has been chosen for special attention for two reasons. First, it highlights some of the particularly acute conflicts between public and private interests which have been posed by HIV/AIDS. Second, it has been the unquestioned foundation of so many disease control programmes in the past and has already been implemented for HIV/AIDS in a majority of countries in the developed world.<sup>1</sup> This study will look at how compulsory HIV/AIDS case-

<sup>&</sup>lt;sup>1</sup> World Health Organization, <u>Tabular Information on</u> <u>Legal Instruments Dealing with AIDS and HIV Infection</u>, Geneva, June 1988.

reporting has been used in Canada and elsewhere and will question the legitimacy and efficacy of this form of public health intervention.

The structure of the study is to look first at how the concept of public health has developed, and how this, in turn, has led to the use of legislation to achieve public health goals. The jurisdictional and constitutional issues surrounding the use of public health legislation in Canada will be considered. In chapter III, existing case-reporting requirements relating to HIV/AIDS in Canada will be examined and compared with those in three other countries with similar patterns of HIV infection. Finally, the public health objectives sought to be achieved by the use of compulsory case-reporting will be analysed in order to determine the extent to which reporting requirements in Canada can and do achieve those objectives.

In undertaking this study, it is important to realise that the issues and confrontations raised by compulsory case-reporting for HIV/AIDS are not susceptible of easy solution. However, it is also important to recognise that any public health response to HIV/AIDS must be based on a careful and complete consideration of all dimensions of the problem, having regard to both public and private interests. As this study will show, the existing statutory framework of

public health legislation in Canada neither reflects nor facilitates such a considered response, and indeed, may be hindering public health measures against HIV/AIDS.

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#### **<u>II. PUBLIC HEALTH IN CANADA</u>**

#### A. THE CONCEPT OF PUBLIC HEALTH

Although the notion that health is a matter of legitimate public concern is rarely questioned today, the history of the development of public health interventions shows that this has not always been the case. The idea that the preservation of public health was an interest that could and should be protected by the state is one that has had a troubled birth, and tensions between measures taken by public health authorities to combat disease and other rights claimed by individual citizens have been a feature of public health interventions for many centuries.

At the heart of these tensions is the question of what is meant by the expression "public health". If one accepts, in principle, that state intervention to protect public health can be justified, one must also define what it is that constitutes public health. Is public health merely the sum total of the health of all the individuals in a community or is there some collective notion of health that is qualitatively different from private health? Is health itself something that is able to be objectively defined, and

if not, how do we decide how the notion of public health will be applied in any given circumstance?

These are complex questions which have rarely been confronted, either by courts or by policy-makers. The history of the use of public health measures shows that although a wide range of different interventions have been implemented ostensibly in the interests of public health, the idea of what constitutes public health has tended to be implicit rather than explicit. Thus, the concept of public health today is shaped to large extent by a body of historical precedents and unspoken assumptions about health which, in turn, have shaped and will continue to shape the public health response to HIV/AIDS.

# 1) <u>Historical Development of the Concept of</u> <u>Public Health</u>

The imposition of public health measures to curb the spread of disease can be traced back to medieval Europe, when the Black Plague was at its height. The devastating effects of this epidemic led municipal officials in a number of European cities to adopt harsh measures in an effort to contain the disease. Regulations were passed to improve public sanitation and to ensure the swift removal of the bodies of plague victims. Frequently, infected persons were

isolated from the rest of the population in the hope that this would reduce the spread of the disease. Although these isolation measures were markedly unsuccessful in bringing the plague under control, as the infection was in fact spread by rats and fleas, the use of isolation persisted for the duration of the epidemic.<sup>2</sup>

Even at the height of the plague, however, these public health measures were often controversial, and were the subject of much criticism and opposition. In Milan and Venice, where public health boards were established and given broad powers to do whatever was considered necessary to control the epidemic, opposition was particularly vocal. Many townspeople complained about the restriction of their movements, the confiscation of property believed to be contaminated, and the imposition of sanitary controls over foodstuffs and other goods. At times, these protests became violent, leading to the imposition of strict penalties (including torture) for those who failed to comply with the public health ordinances.<sup>3</sup>

<sup>3</sup> <u>Ibid</u>., at 124-125.

<sup>&</sup>lt;sup>2</sup> R.S.Gottfried, <u>The Black Death: Natural and Human</u> <u>Disaster in Medieval Europe</u>, (New York: The Free Press, 1983), at 64-69 and 122-125.

Public health programmes implemented during the time of the Bubonic plaque provided a precedent for subsequent epidemics of smallpox, yellow fever and cholera. When cholera struck Europe in the nineteenth century, strict quarantine requirements were imposed upon those infected and efforts were made to prevent travellers from entering within town precincts in the belief that they may have been carrying disease.<sup>4</sup> In North America, where the effects of these diseases were no less severe, quarantine measures against smallpox were imposed as early as 1622, and the first quarantine statute was enacted in the United States in 1796 in response to a yellow fever epidemic.<sup>5</sup> Other measures imposed to prevent infectious disease during this period included compulsory innoculations for smallpox<sup>6</sup> and restrictions on the sale of certain foods<sup>7</sup>.

Once again, however, these measures did not go unchallenged. During the nineteenth century, courts in the

Ostrow et al., <u>supra</u>, note 4, at 23.

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<sup>&</sup>lt;sup>4</sup> D.G.Ostrow. M.Eller & J.G.Joseph, "Epidemic Control Measures for AIDS: A Psychosocial and Historical Discussion of Policy Alternatives", in I.B.Corless & M.Pittman-Lindeman (eds.), <u>AIDS: Principles, Practices & Politics</u>, (New York: Hemisphere Publishing Corporation, 1988), at 22.

W.E.Parmet, "AIDS and Quarantine: The Revival of an Archaic Doctrine", (1985) 14 <u>Hofstra Law Review</u> 53, at 56-57.

<sup>&</sup>lt;sup>6</sup> D.Jones Merritt, "The Constitutional Balance Between Health and Liberty", (1986) 16 <u>Hastings Center Report</u> 2, at 3.

United States saw an increasing number of cases in which it was argued that public health laws were invalid on the basis that they encroached unreasonably upon individual rights. Challenges were mounted against compulsory vaccinations, against smallpox and leprosy quarantine, and against the confiscation of property for public health purposes.<sup>8</sup> However, while this litigation is indicative of the controversy surrounding the use of public health powers, it is significant that the courts consistently upheld the use of such powers, stating in one case that public health was "the highest law of the land" and that in the face of public health needs, "all constitutionally guaranteed rights must give way".<sup>9</sup> Similarly, the imposition of quarantine was upheld by the courts as a legitimate use of police powers.<sup>10</sup>

There was therefore an evolving jurisprudence in the nineteenth century which held that public health was an important government concern which could be used to justify a wide range of restrictive measures. While these measures did not go unchallenged, the courts, when called upon to adjudicate between public and private interests, came down

<u>Beeks</u> v. <u>Dickinson County</u>, 108 N.W. 311 (1906), at
 312, as cited in Merritt, <u>Ibid</u>., at 3.

<sup>10</sup> Parmet, <u>supra</u>, note 5, at 60.

<sup>&</sup>lt;sup>8</sup> For a detailed discussion of these cases, see Merritt, <u>supra</u>, note 6, at 3-6.

strongly on the side of public health as the overriding consideration.

A number of factors could be seen as influencing this judicial deference to public health authorities, which seems to have been closely related to the political climate at the time. Among these factors were the belief in the division of power between courts and legislators, the unwillingness on the part of judges to contradict opinions expressed by medical experts, and on a more fundamental level, a more limited definition of individual rights.<sup>11</sup> Through these various judicial pronouncements on matters relating to public health, it is possible to see the evolution of a philosophy governing how the notion of health could be used in the public context.

## 2) Public Health and Social Values

An important part of this evolution was the association between the concept of public health and the social values of the time. It has been suggested that judicial tolerance towards restrictive public health measures was due in part to cultural factors, such as the desire to respond to the problems of increasing urbanisation and to remove any

Merritt, <u>supra</u>, note 6, at 3-5.

obstacles to further economic development.<sup>12</sup> Similarly, notions of what constituted public health were influenced by social attitudes towards certain social groups or the desire to proscribe certain forms of behaviour.

This is perhaps most clearly illustrated by the response to venereal disease in the nineteenth and twentieth Until well into this century, public health centuries. campaigns against syphilis focussed not so much upon available treatments and prevention measures as on attempts to reinforce traditional moral values, the decline of which was seen as the main source of the disease. Thus, the identification of health with morality - and, conversely, ill health with immorality - was seen to emerge. This was reflected in a number of public health measures, such as the "quarantine" of prostitutes during the First World War, which had little basis in medical science but which operated rather as a symbol of social perceptions of the disease.<sup>13</sup>

These expressions of values which were implicit in the concept of public health can also be seen in other uses of

<sup>&</sup>lt;sup>12</sup> <u>Ibid</u>., at 4.

<sup>&</sup>lt;sup>13</sup> A.Brandt, <u>No Magic Bullet: A Social History of</u> <u>Venereal Disease in the United States since 1880</u>, (New York: Oxford University Press, 1987), at 52-96, and "The Syphilis Epidemic and Its Relation to AIDS", (1988) 239 <u>Science</u> 375, at 376-378.

public health powers earlier this century. In San Francisco, for example, city authorities responded to nine reported cases of the Bubonic plague by passing a ordinance that placed the Asian quarter of the city under quarantine while exempting non-Asian households in the same area. In striking down the quarantine ordinance, a United States federal court noted that no sound rationale existed for the quarantine which appeared to be merely a subterfuge for racial discrimination.<sup>14</sup> Similar motives can be seen in the use of public health powers to quarantine Japanese-Americans during World War II.<sup>15</sup> The culmination of this form of use, or abuse, of public health powers was perhaps the establishment of the Warsaw ghettos pursuant to quarantine powers then found in German public health legislation.<sup>16</sup>

These latter examples, although extreme, illustrate the complexity of the concept of public health and the variety of historical and social values which underpin present public health policy. There can be no doubt that public health is now an acknowledged social concern, the protection of which can legitimately be undertaken by the state. At

<sup>&</sup>lt;sup>14</sup> <u>Jew Ho</u> v. <u>Williamson</u>, 103 F.10, 11-12 (N.D.Cal. 1900), as cited in Parmet, <u>supra</u>, note 5, at 71.

<sup>&</sup>lt;sup>15</sup> <u>Ibid</u>., at 69.

<sup>&</sup>lt;sup>16</sup> R.Proctor, <u>Racial Hygiene: Medicine Under the Nazis</u>, (Cambridge, Harvard University Press, 1988), at 162.

the same time, however, it must also be acknowledged that the way in which public health is defined is an expression of certain social values, which may themselves not be universally accepted. Moreover, the characterisation of certain forms of social intervention as necessary to promote public health may serve to obscure these values and give the interventions an outward legitimacy that may perhaps not be warranted. It is against this background that the use of public health legislation in the context of HIV/AIDS must be analysed.

These questions are far from being merely theoretical. In deciding what measures we are prepared to use to prevent the spread of HIV, we are necessarily both defining what we mean by public health and placing a value on that concept. When seen in historical context, the importance of this value is evident, as is the need to mediate between this and other differing values. This is the process that must now be undertaken in order to determine the role that public health legislation can and should play in the response to HIV/AIDS.

## **B. PUBLIC HEALTH LEGISLATION**

## 1) <u>Constitutional Issues</u>

## i) Jurisdiction

The Canadian Constitution<sup>17</sup> does not expressly assign "health" in general as either a federal or a provincial head of power. The question of whether jurisdiction over a particular matter rests with the federal or the provincial legislatures must therefore be determined according to the purpose and effect of the health measure in issue<sup>18</sup>, and in light of the health-related powers which the Constitution does expressly assign. Among the heads of power which may be relevant in this context are the provincial powers over "public health as a local or private matter"<sup>19</sup> and hospitals.

<sup>18</sup> P.W.Hogg, <u>Constitutional Law of Canada</u>, 2nd ed.

<sup>&</sup>lt;sup>17</sup> <u>Constitution Act, 1982</u>, being Schedule B of the <u>Canada Act 1982</u> (U.K.), 1982, c.11.

other than marine hospitals<sup>20</sup>, and the federal quarantine power.<sup>21</sup>

Despite the absence of an express constitutional provision dealing with jurisdiction over public health in general, provincial jurisdictional competency in this area has rarely been challenged. As early as 1886, it was held that provincial regulations designating a building as a hospital for people infected with smallpox were <u>intra vires</u>, on the basis that the local dimension of the health problem was such as to bring it within the provincial power over public health as a local or private matter.<sup>22</sup> Subsequent decisions have continued to uphold the provincial power to legislate to control epidemics of contagious diseases and to promote public health.<sup>23</sup>

However, although there have been a number of judicial decisions concerning provincial jurisdiction over public

<sup>22</sup> Mackinnon & Krever, <u>Ibid</u>., at 353.

<sup>23</sup> Ibid.

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<sup>&</sup>lt;sup>20</sup> <u>Ibid</u>., s.92(7).

<sup>&</sup>lt;sup>21</sup> <u>Ibid.</u>, s.91(11). It should be noted, however, that this power is probably limited to the detention of foreign ships and immigrants and visitors coming to Canada from other countries. See M.Mackinnon & H.Krever, "Legal and Social Aspects of AIDS in Canada", in Royal Society of Canada, <u>AIDS:</u> <u>A Perspective for Canadians, Background Papers</u> (Ottawa, 1988) 347, at 353.

health, there has been no satisfactory definition of precisely what constitutes public health for these purposes. Thus, when deciding whether a particular piece of legislation falls within the constitutional power of the provinces over public health as a local or private matter, the best that can be said is that public health in this context means what the courts say it is in each case. This offers little insight into whether or not the particular measure under scrutiny in each case will be regarded as a valid exercise of the public health power.

Difficult constitutional questions also arise when there is a potential overlap between the provincial public health jurisdiction and other matters expressly designated as falling within federal jurisdiction. This could occur, for example, if provincial public health legislation contains provisions for the apprehension and detention of infected persons which are alleged to be punitive in nature, thereby falling under the federal criminal law power under s.91(27) of the Constitution and outside provincial legislative competence. Another federal power which could provide a basis for federal jurisdiction over public health matters is the residual power to legislate with respect to peace, order and good government, which may authorise federal legislation dealing with health problems which have

attained a national dimension or which constitute an emergency.<sup>24</sup>

These questions were considered by the Supreme Court of Canada in <u>Schneider</u> v. <u>The Queen</u><sup>25</sup>, a case which dealt with the constitutional validity of the British Columbia <u>Heroin</u> <u>Treatment Act</u>.<sup>26</sup> The Act provided, among other things, for the detention and compulsory treatment of heroin addicts, and had been challenged on the basis that it was punitive in nature and therefore outside provincial jurisdiction. The Supreme Court upheld the validity of the Act pursuant to the provincial power over public health as a local or private matter, thereby confirming that this power grants the provinces extensive jurisdiction over public health. On this question, Dickson J. commented:

"The view that the general jurisdiction over health matters is provincial (allowing for a limited federal jurisdiction either ancillary to the express heads of power in s.91 or the emergency power under peace, order and good government) has prevailed and is now not seriously questioned."<sup>27</sup>

However, the court also stated that the problem of narcotic addiction at that time was not such as to be of national concern. If this were to change, the federal

24	Hogg, <u>supra</u> , note 18, at 405.
25	[1982] 2 S.C.R. 112.
26	S.B.C. 1978, c.24.

<sup>27</sup> <u>Supra</u>, note 25, at 137.

legislature could have jurisdiction in the matter pursuant to the powers mentioned above.<sup>28</sup> In this regard, it should also be noted that the federal government has undisputed jurisdiction under the criminal law power to pass legislation punishing behaviour that is considered dangerous to public health.<sup>29</sup>

What then does this mean for the constitutional validity of public health legislation relating to HIV/AIDS? In view of the decision in <u>Schneider</u>, provincial jurisdiction over public health is well-established, and may even permit measures that could be characterised as "punitive" in effect, such as compulsory medical examinations and the detention and isolation of infected persons or their contacts, where the intent of these measures is to promote or protect public health. Such legislation would seem to fall squarely within the provincial power over public health as a local or private matter as it has been interpreted by the Supreme Court of Canada.

It is not inconceivable, however, that Federal parliament could assert jurisdiction to pass legislation

<sup>29</sup> Hogg, <u>supra</u>, note 18, at 405.

<sup>&</sup>lt;sup>28</sup> <u>Ibid</u>., at 131.

dealing with HIV/AIDS as it relates to matters of national welfare. It could no doubt be argued that the problem is already one of national proportions even if it falls short of an emergency. In opposition to this view, it has been suggested that the geographical concentration of high rates of HIV seroprevalence within certain urban areas of Canada points to the "local" nature of the public health problem, and makes it more closely analogous to measures to control epidemic diseases in the past which have been held to fall within provincial jurisdiction.<sup>30</sup> As the pattern of the disease changes, however, the argument in favour of federal jurisdiction in this area may become stronger.

Whether federal parliament will seek to use a constitutional head of power to pass legislation governing matters relating to HIV/AIDS remains an open question. In the meantime, the scope for any challenge to provincial public health legislation based on jurisdictional grounds is limited, and any such challenge would seem to be unlikely to succeed. However, since 1982 an alternative - and probably more fruitful - avenue for challenging the constitutional validity of provincial public health legislation has been available in the form of the <u>Canadian Charter of Rights and</u> <u>Freedoms</u>.

Mackinnon & Krever, <u>supra</u>, note 21, at 353.

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## ii) The Canadian Charter of Rights and Freedoms<sup>31</sup>

With the enactment of the Charter of Rights and Freedoms in 1982, constitutional protection for human rights in Canada was established for the first time. The Canadian Bill of Rights<sup>32</sup> had existed since 1960, and remains in force notwithstanding the enactment of the Charter. However, the Bill of Rights is not entrenched in the Constitution and applies only to federal and not to provincial laws.<sup>33</sup> Moreover, while it has been held that the Bill of Rights can render inoperative federal statutes passed prior to the enactment of the Bill, its effect on subsequent legislation is open to guestion.<sup>34</sup> In practice, the Bill of Rights does not seem to have represented a significant restriction on federal legislative powers, with only one statute ever having been declared inconsistent with the provisions of the Bill.35

- <sup>32</sup> R.S.C. 1970, Appendix III.
- <sup>33</sup> Hogg, <u>supra</u>, note 18, at 639.
- <sup>34</sup> <u>Ibid</u>., at 643-645.

<sup>35</sup> This was the decision of <u>R</u>. v. <u>Drybones</u>, [1970] S.C.R. 282. See <u>Ibid</u>.

<sup>&</sup>lt;sup>31</sup> Part I of the <u>Constitution Act</u>, 1982, being Schedule B of the <u>Canada Act</u> 1982 (U.K.), 1982, c.11.

In contrast, the Charter of Rights and Freedoms has been shown to offer substantial protection for a wide range of rights in Canada. In the context of HIV/AIDS, where concerns about the rights of infected persons are paramount, there can be no doubt that questions of validity under the Charter will be raised in order to challenge legislative measures affecting persons infected with HIV. As the Charter is applicable to both federal and provincial legislation<sup>36</sup>, it is an important factor to be taken into account when considering the operation and effect of provincial public health laws.

### a) Protected Rights

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There are a number of provisions in the Charter which are relevant in this context. Section 7 provides that everyone has the right to "life, liberty and security of the person" and the right not to be deprived of these "except in accordance with the principles of fundamental justice". Section 8 enunciates the right to be secure against "unreasonable search or seizure", while section 9 protects the right "not to be arbitrarily detained or imprisoned". Under section 10, any person arrested or detained has the right to be informed of the reasons for the detention and to

<sup>36 &</sup>lt;u>Canadian Charter of Rights and Freedoms</u>, <u>supra</u>, note 31, s.32(1).

challenge the validity of the detention by way of <u>habeas</u> <u>corpus</u>. Section 12 protects the right not to be subjected to "cruel and unusual treatment or punishment."

There is, in addition, a statement in section 15 that every person is equal before and under the law and has the right to the equal protection and benefit of the law without discrimination, and in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability. Although there has not yet been any decision under the Charter based upon a finding that AIDS or HIV infection constitutes a "physical disability" for the purposes of this section, the Canadian Human Rights Commission and several provincial Human Rights Commissions have issued policy statements to the effect that HIV/AIDS falls within the meaning of "disability" under applicable provincial human rights codes.<sup>37</sup> In an as yet unreported decision handed down by the British Columbia Human Rights Commission on 6th October, 1988, in the matter of Biggs v. Hudson, it was held that both actual and perceived HIV infection were protected grounds of discrimination under the British Columbia Human Rights

<sup>&</sup>lt;sup>37</sup> See, for example, Canadian Human Rights Commission, "Policy on Acquired Immunodeficiency Syndrome", adopted May 1988, and Quebec Human Rights Commission Working Paper, "Le Sida et le Respect des Droits et Libertés de la Personne", issued 15 January 1988.

<u>Act</u>.<sup>38</sup> It is therefore strongly arguable that, by analogy, section 15 of the Charter will also be held to apply to persons with AIDS or who are infected with HIV, and possibly also those who are perceived as being infected with HIV.

To carry out a thorough analysis of how these provisions of the Charter will be interpreted and applied in the context of public health legislation and HIV/AIDS would be a separate study in itself, and is not possible within the limits of this thesis. It is important, however, to highlight some of the general principles which may influence the approach of the courts when called upon to determine whether provisions in public health legislation are inconsistent with the protection afforded by the Charter.

## b) <u>General Interpretive Principles</u>

The first point to note is that the rights expressed in the Charter are not given absolute protection. Under section 1, the rights are stated to be guaranteed "subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society". This section expressly acknowledges that there may be circumstances where the overriding of a Charter right can be

<sup>38</sup> S.B.C. 1984, c.22.

justified by some more important social objective, and therefore embodies the concept of a balancing process between the rights protected by the Charter and other social interests.

When considering the application of section 1, the Supreme Court of Canada has held that one must first determine which government objectives are sufficiently important to warrant overriding a Charter right.<sup>39</sup> The objective must relate to concerns which are "pressing and substantial in a free and democratic society".<sup>40</sup> It is then necessary to decide if the means chosen to override the right are reasonable; the measures adopted must be carefully designed to achieve the objective in question, they must not be arbitrary, unfair or based on irrational considerations, and they should impair the right in question as little as possible.<sup>41</sup> Finally, there must be a "proportionality" between the effects of the measures adopted and the objective sought to be achieved. The more severe the effects of a measure, the more important the objective must

39 <u>R. v. Big M Drug Mart Ltd</u> [1985] 1 S.C.R. 295, at 352.

<sup>40</sup> <u>R. v. Oakes</u> [1986] 1 S.C.R. 103, at 138-139.
 <sup>41</sup> Ibid., at 139.

be to warrant the overriding of a Charter right pursuant to section 1.42

These principles provide some insight into how public health legislation could be challenged under the Charter. Clearly, the public health objective must be a powerful one, although this is unlikely to be seriously at issue in the case of HIV/AIDS. More importantly, public health measures will be open to challenge if they are not carefully designed to achieve a particular public health purpose which is justified and if they do not adopt the least restrictive means of achieving that purpose. In the event that there is a substantial encroachment upon one of the rights under the Charter, there must be a correspondingly large public health benefit to be gained from the imposition of that measure.

One other important point to note in relation to the application of the Charter in this context is that there is a provision in section 33 enabling federal parliament or a provincial legislature to declare expressly that certain legislative provisions shall continue to operate notwithstanding any breach of the Charter. Although this override provision has never been invoked with respect to

<u>Ibid</u>., at 139-140,

public health legislation, its existence serves to weaken the potential protection offered by the Charter.

It is clear that there are a number of provisions in public health legislation which could be subject to review under the Charter. Mandatory medical examinations, contacttracing and restrictions on the right of persons infected with a communicable disease to attend school or travel on public transport<sup>43</sup>, could be held to be an infringement of the rights to liberty, security of the person and equality before and under the law. Quarantine and isolation measures could be challenged on the basis of a number of Charter rights, including the right to liberty and security of the person, the right not to be arbitrarily detained, and the right not to be subjected to cruel and unusual treatment. In the context of the present study, however, the question of the validity of compulsory case-reporting provisions under the Charter is the one to which closer attention will be given.

<sup>&</sup>lt;sup>43</sup> Restrictions such as this are not uncommon in Canadian provincial public health legislation, and in some cases apply to persons who have AIDS or are infected with HIV. For example, the Newfoundland <u>Communicable Diseases Act</u> R.S.N. 1970, c.52, s.16, and the Nova Scotia <u>Health Act</u> R.S.N.S., 1967, c.247, s.71.

## b) Compulsory Case-Reporting and the Charter

It could be argued that case-reporting provisions infringe the right to security of the person under section 7 of the Charter<sup>44</sup>. The Supreme Court of Canada has held that "serious state-imposed psychological stress" and harm to a person's "psychological integrity" can both constitute a breach of the right to security of the person.<sup>45</sup> It has also been suggested that "security of the person" could include a person's reputation as well as physical security.<sup>46</sup> All these interpretations establish grounds upon which case-reporting provisions could be challenged under section 7.

Section 7 establishes a qualified right to security of the person in that the right can be impaired as long as the principles of fundamental justice are respected. The question of what the principles of fundamental justice require in this context is still not entirely settled. In earlier decisions under the Charter, it was suggested that this requirement relates only to questions of procedural

<sup>&</sup>lt;sup>44</sup> Section 7 provides: "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 justice."

 <sup>&</sup>lt;sup>45</sup> <u>R. v. Morgentaler</u>, [1988] 1 S.C.R. 30, at 56 and 60.
 <sup>46</sup> Hogg, <u>supra</u>, note 18, at 745.

fairness and not to the substantive content of the measure under challenge.<sup>47</sup> More recently, however, in the decision of <u>R</u>. v. <u>Morgentaler</u><sup>48</sup>, the Supreme Court of Canada has questioned the drawing of a sharp line between substantive and procedural issues in this context, leaving the way open for some degree of substantive review of the merits of the case in order to determine whether the breach of the section 7 right has been in accordance with the principles of fundamental justice.<sup>49</sup>

This leaves some uncertainty surrounding the question of whether case-reporting provisions could be found to infringe section 7. Clearly, they would be more likely to withstand a constitutional challenge if the procedures adopted for reporting are fair and reasonable. However, since the <u>Morgentaler</u> decision, there exists the possibility of a more fundamental challenge to the substance of casereporting requirements pursuant to section 7 of the Charter, which could conceivably encompass such questions as whether the effect and implications of reporting requirements are reasonable in view of the objective sought to be achieved.

- <sup>48</sup> <u>Supra</u>, note 45.
- <sup>49</sup> <u>Ibid</u>. at 52-53.

<sup>&</sup>lt;sup>47</sup> See, for example, <u>The Queen</u> v. <u>Operation Dismantle</u> [1983] 1 F.C. 745, at 746-749.

The equality rights under section 15 of the Charter may also offer an avenue for challenging compulsory casereporting provisions.<sup>50</sup> As it seems highly likely that both AIDS and HIV seropositivity would be found to constitute a "physical disability" for the purposes of this section<sup>51</sup>, any law which "discriminates" against persons with HIV/AIDS by treating them differently from others could infringe section 15, if such discrimination is found to be wrongful. The question of what amounts to "discrimination" in this context is a difficult one. There is authority to suggest that section 15 will be infringed only where the discrimination can be shown to have some adverse or prejudicial effect.<sup>52</sup> In the case of disease reporting provisions, it could be argued that the adverse effects flow not so much from the reporting provisions themselves as from government interventions, such as contact-tracing, which are based on the reports. However, perhaps a stronger argument is that the loss of privacy resulting from the reporting

<sup>&</sup>lt;sup>50</sup> Section 15 provides: "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."

<sup>&</sup>lt;sup>51</sup> Supra, at 23-24.

<sup>&</sup>lt;sup>52</sup> <u>McKinney</u> v. <u>University of Guelph</u>, (1987) 24 O.A.C. 245, at 271.
process itself is sufficient to attract the protection of section 15.

In the event that a reporting provision is found to be in breach of section 7 or section 15, it may still be saved by section 1. The question of whether the overriding of the right could be demonstrably justified in a free and democratic society would have to be decided according to the general principles outlined above. It would have to be shown, for example, that the reporting requirement was directed towards a legitimate public health objective, was effective in achieving that objective, and that in doing so, it encroached upon the protected right as little as possible.

In this regard, the decision of the United States Supreme Court in <u>Whalen</u> v. <u>Roe</u><sup>53</sup> may offer some guidance. This was a case in which the constitutional validity of a New York statute requiring the reporting of the names and addresses of people obtaining certain prescription drugs was challenged on the basis that it infringed the right to privacy. The court held that the reporting provision would be constitutional if it was reasonably related to a valid public health objective and as long as there were regulatory

<sup>53</sup> 429 U.S. 589 (1977).

safeguards to ensure that only authorised officials could obtain access to the information.<sup>54</sup> In relation to reporting requirements generally, the court commented:

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"...disclosures of private medical information to doctors, to hospital personnel, to insurance companies, and to public health agencies are often an essential part of modern medical practice even where the disclosure may reflect unfavorably on the character of the patient. Requiring such disclosures to representatives of the State having responsibility for the health of the community does not automatically amount to an impermissible invasion of privacy."<sup>55</sup>

It should be noted that this decision hinged upon the right to privacy in the United States which has been developed as a penumbra right under the Constitution. This right is not found in the Canadian Charter, and so far has not been implied. Despite this difference, however, the decision is consistent with the principles laid down by Canadian courts for interpreting the Charter, in that it looks at the competing public and private interests. It therefore provides an example of how Canadian courts might approach this question. The conclusion to be drawn is that compulsory case-reporting provisions may be able to be justified on the basis of an important public health objective, but in order to withstand a challenge under the

<sup>&</sup>lt;sup>54</sup> See W.J.Curran, M.E.Clark & L.Gostin, "AIDS: Legal and Policy Implications of the Application of Traditional Disease Control Measures", (1987) 15 <u>Law, Medicine and Health</u> <u>Care</u>, 27, at 28.

<sup>&</sup>lt;sup>55</sup> <u>Supra</u>, note 53, at 602.

Charter, they must be carefully drafted so as to achieve this objective in the least restrictive way possible.

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# 2) An Overview of Public Health Legislation relating to HIV/AIDS

The jurisdictional questions surrounding the exercise of public health powers in Canada have already been discussed. It has been seen that provincial jurisdiction over public health is widely acknowledged and has been upheld by the courts on many occasions.<sup>56</sup> This in turn determines the legislative framework which exists in Canada today to govern the exercise of public health powers, and within which the public health response to HIV/AIDS will take place.

Because jurisdiction over public health has been assumed by the provinces, each of the twelve Canadian jurisdictions has its own different legislation and regulations governing public health. An analysis of the statutory framework relevant to the exercise of public health powers in the context of HIV/AIDS must therefore include a consideration of twelve different statutory

<sup>56</sup> <u>Supra</u>, at 15-19.

regimes in addition to the potential scope of federal jurisdiction in this area.

Two consistent themes can be seen to emerge from a comparative study of provincial public health legislation in Canada as it applies to HIV/AIDS. In the first place, it soon becomes clear that the legislation of the various jurisdictions is distinguished more by its differences than by its similarities. The different Public Health instruments vary enormously in age, one dating back as far as 1938<sup>57</sup> with others having been substantially revised within the last ten years.<sup>58</sup> They vary in their subjectmatter, their scope, their terminology and their substantive provisions, with the result that it could not be said that there is any consistency across Canada in the nature and extent of the powers vested in public health authorities. Depending upon where cases of a particular disease occur, the nature of the public health response may be very different.

A second theme that emerges concerns the way in which provisions dealing with HIV/AIDS have been incorporated into

<sup>&</sup>lt;sup>57</sup> Nova Scotia <u>Regulations in Respect of the</u> <u>Communicable Diseases</u>, see <u>infra</u>, note 67.

<sup>&</sup>lt;sup>58</sup> For example, the <u>Health Act</u> R.S.B.C. 1979, c.161, and the <u>Health Protection and Promotion Act</u> S.O. 1983, c-10.

provincial public health legislation. All the Canadian provinces and the two territories have passed statutory amendments or regulations which have the effect of bringing at least some form of HIV-related disease under the umbrella of the public health legislation applicable in the particular jurisdiction. Without exception, the pattern followed has been to add "AIDS", "ARC" or "HIV infection" (or some terminological variant thereof) to a list of diseases contained in the Act, usually in one of the Schedules, described variously as "communicable", "designated", "notifiable" or "reportable" diseases. The inclusion of the HIV-related disease in this list has the effect of making a number of existing provisions in the Act applicable to cases of the HIV-related disease.<sup>59</sup>

This has meant that the differences already existing between the public health legislation of the various jurisdictions are reproduced in the legislative framework applicable to HIV/AIDS. A further consequence is that the provisions of the various public health Acts which now apply to HIV/AIDS are, to a large extent, the same as the provisions applicable to the other listed diseases, which commonly include such diseases as cholera, typhoid and tuberculosis. This is despite the fact that HIV/AIDS has

<sup>&</sup>lt;sup>59</sup> These provisions are discussed in detail in Chapter III.

characteristics which make it different from many of these other communicable diseases, such as the relatively limited means of transmission and the fact that a person infected with the virus may remain asymptomatic for long periods of time. Thus, the piecemeal amendment of public health legislation in response to HIV/AIDS seems to have shown little consideration of which specific measures might be effective in containing the spread of the virus and which might be inappropriate or even harmful.

Compulsory case-reporting provisions in Canadian public health legislation provide a clear illustration of these problems. The anomalies and inconsistencies in the reporting provisions of the various provinces are manifest. As the following analysis will show, there is good reason to doubt whether the existing provisions are indeed appropriate for addressing the issues raised by HIV/AIDS.

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#### III. COMPULSORY CASE-REPORTING OF HIV/AIDS

The cornerstone of communicable disease control programmes has traditionally been a system of compulsory reporting to public health authorities of cases of a particular disease. The rationale behind this approach is essentially twofold: compulsory case-reporting is thought to provide necessary epidemiological information about the incidence and prevalence of the disease and to facilitate measures to control the spread of the disease by identifying infected individuals who can then be counselled, and if appropriate, isolated and treated.<sup>60</sup> This pattern of disease control has been used frequently in the past with a wide range of different diseases<sup>61</sup>, many of which are still reportable today in Canadian jurisdictions and elsewhere.

It is hardly surprising, therefore, that the same pattern has been followed with HIV/AIDS. Cases of AIDS are now reportable in all Canadian provinces and the two territories, and in all American states, as well as in a

<sup>&</sup>lt;sup>60</sup> Curran et al., <u>supra</u>, note 54, at 27.

<sup>&</sup>lt;sup>61</sup> See generally, D.M.Fox, "From TB to AIDS: Value Conflicts in Reporting Disease", (1986) 16 <u>Hastings Center</u> <u>Report</u> 11. For an interesting discussion of the use of disease-reporting in relation to venereal disease, see A. Brandt, <u>No Magic Bullet: A Social History of Venereal Disease</u> in the United States since 1880, <u>supra</u>, note 13.

large number of other countries around the world.<sup>62</sup> Naturally, the reporting duties differ from country to country, but there appears to be a widespread adherence, in principle, to the practice of compulsory case-reporting.

The question of whether this belief in the efficacy of case-reporting as a discase control measure is well-founded will be considered in the following chapter. Before doing so, however, it is helpful to look more closely at the reporting duties applicable to HIV/AIDS under existing public health legislation in Canada and elsewhere in order to highlight some of the difficulties associated with casereporting in this context. Some of these difficulties, it will be argued, stem from the use of inappropriate statutory provisions, which may well be ineffective in achieving the desired public health objectives, and in some cases, may actually hinder these objectives.

<sup>&</sup>lt;sup>62</sup> These include many Third World countries in addition to developed nations. See the <u>World Health Organization</u> <u>Tabular Information on Legal Instruments Dealing with AIDS and</u> <u>HIV Infection</u>, <u>supra</u>, note 1.

#### A. <u>CANADA</u>

# 1) <u>Compliance</u>

# i) <u>Disease Classifications</u>

One of the difficulties of applying provincial public health legislation in the context of HIV/AIDS arises from the disease classifications used in relevant Act. Many of the Acts have a number of different classifications of disease, such as "notifiable" diseases, "communicable" diseases and "infectious" or "contagious" diseases, each of which brings into play a different set of statutory provisions. Some of these classifications are constituted by a list of specified diseases, while other classifications are described only in very general terms. In British Columbia, for example, the <u>Health Act<sup>63</sup></u> contains a number of specific provisions relating to either "contagious" or "infectious" diseases. "Contagious" is defined to mean "communicable by close contact or inoculation", while "infectious" is defined as "communicable in any manner, even at a distance".<sup>64</sup> Either of these definitions could

<sup>63</sup> <u>Supra</u>, note 58.

<sup>64</sup> <u>Ibid.</u>, s.1.

encompass AIDS even though the only express reference to AIDS in the Act is its designation as a "communicable" disease - yet a third classification under the Act. As a result, three separate sets of statutory provisions are applicable to AIDS in British Columbia.

The lack of precision and the overlapping in the classifications used can lead to ambiguities in the reporting duties imposed. This can be seen in Manitoba where AIDS has been specifically designated as a "sexually transmitted" disease under the Regulations but also falls within the definition of "notifiable disease" under the same Regulations, thereby triggering two separate, and not entirely consistent, reporting duties.<sup>65</sup> It is not clear whether one duty could be construed as overriding the other or whether two reports must be made for each case of the disease, one to the Director of Preventive Medical Services with respect to the notifiable disease and a second to the Director of Communicable Disease Control, who is responsible

<sup>&</sup>lt;sup>65</sup> <u>Regulation Respecting Diseases and Dead Bodies</u>, <u>intra</u>, note 67, ss.1(1), 2(1), 5 and 40.

for monitoring sexually transmitted diseases.<sup>66</sup>

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The question of the classification used also raises a more fundamental concern about the way in which legislative provisions such as these can influence how AIDS and HIV infection are perceived on a more general level. To classify the disease only as "sexually transmitted", for example, reflects certain underlying assumptions about the nature of the disease, and perhaps also about the behaviour and responsibility (or irresponsibility) of infected persons. The way the disease is described in public health legislation should not be seen as merely a matter of statutory drafting, because this ignores the symbolic value which attaches to these descriptions.

The disease classification used for HIV/AIDS can also reflect certain assumptions about what measures will be effective to control the spread of the virus. If AIDS is a sexually transmitted disease, the argument might go, then measures taken to combat other sexually transmitted diseases in the past should be implemented without delay. This

<sup>&</sup>lt;sup>66</sup> In practice, in fact, the two different Directors, referred to in the Act are the same person, with the result that only one report is made with respect to each case of AIDS. (Personal communication from Judy Portman, Nurse-Epidemiologist, Sexually Transmitted Disease Control, AIDS Programme, Manitoba Health, January 12, 1989). This highlights the discrepancy that can exist between the actual legal reporting requirements and the practice followed.

reasoning is clearly fallacious when stated in such simplistic terms, but seems nonetheless to be an all too accurate description of the legislative response to HIV/AIDS in many Canadian jurisdictions. The traditional measures will not necessarily be effective in the case of HIV/AIDS, and the use of traditional disease classifications may only serve to compound this problem.

#### ii) Statutory Definitions of AIDS and HIV infection

Although all jurisdictions have added "AIDS" or "Acquired Immune Deficiency Syndrome" to their list of reportable diseases<sup>67</sup>, there is no uniform standard for what

<sup>67</sup> Alberta Public Health Act S.A. 1984, c.P-27.1, as am. S.A. 1988, c.41, s.31(1), and <u>Communicable Diseases</u> Regulation, Alta. Reg. 238/85, Schedules 1 & 3; British Columbia <u>Health Act Communicable Disease Regulation</u>, B.C. Reg. 4/83, s.2 & Schedule A; Manitoba Regulation Respecting Diseases and Dead Bodies, R.R.M. P210-R2, ss.2(1), 5 & 40; New Brunswick <u>General Requlation - Health Act</u>, N.B.Reg. 84-283, ss.96(1) & (2); Newfoundland Communicable Diseases Act 1970 C.52, ss.3-5 and Schedule; Nova Scotia R.S.N. Regulations in Respect of the Communicable Diseases, N.S. Req. 171/85, ss.2 & 11(15A); Ontario Health Protection and Promotion Act, S.O. 1983, c.10, ss.25-29, O. Reg. 161/84, s.1, and O. Reg. 162/84, s.1; Prince Edward Island Notifiable and Communicable Diseases Regulations, P.E.I. Reg. EC330/85, ss.6, 7 & 17; Quebec Public Health Protection Act, S.R.Q., c.P-35, Schedule s.5, and R.R.Q. 1980, c.P-35, s.30 & 13: Saskatchewan Regulations Governing Control and Notification of Communicable Disease, Sask. Reg. 307/69, ss.1(1)(o), 2 & 3; Northwest Territories Public Health Act, R.S.N.W.T. 1984, c.P-10, Schedule A, and Communicable Diseases Regulations, R.R.N.W.T. 1980, Reg. 212, ss.4 & 5 and Schedule A; and Yukon Public Health Act, Y.T.O.I.C. 1987/214, Schedule 1, and <u>Communicable Diseases Regulations</u>, Y.T.O.I.C. 1961/48, s.4.

constitutes a diagnosis of AIDS such as to trigger the duty to report. Unlike the United States where the case definition of AIDS formulated by the Centers for Disease Control has been adopted by all states for reporting purposes<sup>68</sup>, there is no such consistency in Canada. Most of the provincial Public Health Acts contain no definition of AIDS, and those that do define the term do so in very different ways. In Manitoba, for example, the <u>Regulation Respecting Diseases and Dead Bodies</u><sup>69</sup> states that a diagnosis of AIDS shall be made on the basis of:

- a physical examination and medical history;
- a positive test for HIV;
- the occurrence of an opportunistic disease that is at least moderately indicative of immunodeficiency in the absence of any other explanation for the deficiency; and
- any additional medical criteria considered appropriate by the Director of Preventive Medical Services.<sup>70</sup>

This definition should be contrasted with the <u>Regulations in Respect of the Communicable Diseases</u> in Nova Scotia<sup>71</sup> which define "Acquired immune deficiency syndrome" as "including":

- a diagnosis of AIDS, or

- <sup>69</sup> <u>Supra</u>, note 67.
- <sup>70</sup> <u>Ibid</u>., s.34.
- <sup>71</sup> <u>Supra</u>, note 67.

<sup>&</sup>lt;sup>68</sup> Curran et al., <u>supra</u>, note 54, at 28-29.

- one positive result on an ELISA test.<sup>72</sup>

Apart from the fact that it seems less than helpful to define AIDS as "a diagnosis of AIDS", it is medically incorrect to suggest that a positive HIV antibody test result constitutes a case of AIDS, or indeed that "one positive result on an ELISA test" even indicates that the person has been infected with HIV. A strict adherence to this definition would mean that any comparisons between the number of "AIDS" cases in Nova Scotia, for example, and the number in other provinces where different definitions of AIDS are used would be of doubtful value.

The absence of satisfactory and consistent diagnostic guidelines for case-reporting becomes even more significant when one looks at provisions for the reporting of HIV seropositivity. Every jurisdiction in Canada, with the exception of British Columbia, Alberta and Quebec, now requires positive HIV test results to be reported.<sup>73</sup> However, it is well-known that the HIV antibody test can produce both false positive and false negative results. The

<sup>&</sup>lt;sup>72</sup> <u>Ibid.</u>, s.15A.

<sup>&</sup>lt;sup>73</sup> <u>Supra</u>, at 42 and note 67. Although British Columbia and Alberta do not require the reporting of HIV-seropositivity by law, in practice all positive test results in each province are reported to public health authorities by the testing laboratories on a voluntary basis (<u>infra</u>, at 57-58). Thus, Quebec is alone among the provinces in not treating HIV seropositivity as a notifiable condition.

ELISA test which is almost always the first to be carried out is less accurate than the more expensive Western Blot; accordingly, accepted practice is for a confirmatory Western Blot test to be carried out, with a person only being considered to be infected if both tests are positive.<sup>74</sup>

In view of this, there are sound reasons why any statutory duty to report positive HIV test results should apply only to those cases where appropriate confirmatory testing has been carried out. The statutory provisions, however, are far from clear on this point. As mentioned above, Nova Scotia expressly requires unconfirmed positive ELISA test results to be reported<sup>75</sup>, while in Saskatchewan, physicians must report any suspected case of HIV-infection without waiting for laboratory confirmation of the diagnosis.<sup>76</sup> Other provinces have designated "human immunodeficiency virus" or "HIV" as a reportable disease without specifying what diagnostic procedure should be

<sup>&</sup>lt;sup>74</sup> See generally, K.B.Meyer & S.G.Pauker, "Screening for HIV: Can we afford the false positive rate?", (1987) 317 <u>New Eng. J. Med</u>, 238, M.J.Barry, P.D.Cleary & H.V.Fineberg, "Screening for HIV Infection: Risks, Benefits and Burden of Proof", (1986) 14 <u>Law, Medicine and Health Care</u> 259, and D.P.Francis & J.Chin, "The Prevention of Acquired IImmunodeficiency Syndrome in the United States", (1987) 257 J.A.M.A. 1357, at 1359.

<sup>&</sup>lt;sup>75</sup> Supra, at 43-44.

<sup>76 &</sup>lt;u>Regulations Governing Control and Notification of</u> <u>Communicable Disease</u>, <u>supra</u>, note 67, ss.2(1) & (2).

followed.<sup>77</sup> One must question whether this is desirable given the need for accurate and consistent epidemiological information and the potential adverse consequences for anyone incorrectly reported as HIV positive.

Prince Edward Island has adopted a different approach again by designating "HIV antibodies" as a notifiable disease under the sub-category of "sexually transmitted diseases"<sup>78</sup>. This raises two problems. First, the reporting duty would presumably extend to persons (such as children born to HIV-infected mothers) whose blood may contain antibodies to HIV although not actually infected with the virus. Secondly, the designation of both "AIDS" and "HIV antibodies" as sexually transmitted diseases could, on a literal reading, be taken to mean that only cases of infection acquired through sexual contact must be reported. One assumes that this cannot have been the intention of the legislators, but the provision remains ambiguous.

For example, the Saskatchewan <u>Regulations Governing</u> <u>Control and Notification of Communicable Disease</u>, <u>supra</u>, note 67, ss.1(1)(0), 2 & 3, and the Northwest Territories <u>Communicable Diseases Regulations</u>, <u>supra</u>, note 67, ss.4 & 5 and Schedule A.

<sup>&</sup>lt;sup>78</sup> <u>Notifiable and Communicable Diseases Regulations</u>, <u>supra</u>, note 67, s.17(a).

#### iii) When is there a Duty to Report?

The discrepancies between the reporting duties in the various pieces of provincial public health legislation are particularly marked when one looks at the criteria which must be satisfied before the duty to report is triggered. Problems concerning the definitions of AIDS and HIV infection have already been discussed. Further questions arise in relation to the degree of certainty required as to a person's infected status before the report must be made.

On this question, the provisions in the provincial public health legislation range from, on the one hand, a requirement that only actual known cases of AIDS be reported<sup>79</sup>, to a requirement on the other hand that a report be made whenever there is "reason to believe or suspect" that a person is infected.<sup>80</sup> Other statutory criteria include "forming an opinion" that a person is infected<sup>81</sup>,

<sup>79</sup> Quebec <u>Public Health Protection Act</u>, <u>supra</u>, note 67, s.5, and Regulations, <u>supra</u>, note 67, s.30.

Saskatchewan <u>Regulations Governing the Control and</u> <u>Notification of Communicable Disease, supra</u>, note 67, ss.2 & 3, Yukon <u>Communicable Diseases Regulations</u>, <u>supra</u>, note 67, ss3, 4 & 5, and Northwest Territories <u>Communicable Diseases</u> <u>Regulations</u>, <u>supra</u>, note 67, ss.4 & 5.

<sup>&</sup>lt;sup>81</sup> Manitoba <u>Regulations Respecting Diseases and Dead</u> <u>Bodies, supra, note 67, s.40.</u>

"recognising or suspecting" a case of the disease<sup>82</sup>, and "becoming aware" of such a case.<sup>83</sup>

The uncertainty inherent in most of these formulations is self-evident. What is sufficient to give rise to a suspicion that a person is infected? Must the suspicion be based on reasonable grounds? Is any objective medical evidence required before one can form an opinion that a person is infected or is the test a subjective one?

In any event, the justification for compelling a mere suspicion or belief of infection to be reported to public health officials must be questionable, particularly in those provinces where the reporting duty is not limited to physicians and other medically-qualified persons. Any data so obtained would be of doubtful epidemiological value, and public health officials would be wise to require a greater degree of certainty before taking any action against the person suspected of being infected. At one extreme, one can envisage a situation where the knowledge that a certain person is a member of a group at high risk of HIV infection might be sufficient to give rise to a suspicion that the

<sup>&</sup>lt;sup>82</sup> New Brunswick <u>General Regulation - Health Act</u>, <u>supra</u>, note 67, s.96(2).

<sup>&</sup>lt;sup>83</sup> Prince Edward Island <u>Notifiable and Communicable</u> <u>Discases Regulations, supra</u>, note 67, s.17.

person is infected such as to trigger the duty to report. Even where such a report were motivated by prejudice or malice, attempts could be made to defend it on the basis of the perceived legal duty.<sup>84</sup>

#### iv) On Whom is the Duty to Report Imposed?

Similar problems arise when one looks at the class of persons on whom the duty to report is imposed. In some provinces, such as Quebec<sup>85</sup>, only physicians are required to report cases of diseases which have been designated as notifiable. Other Public Health Acts impose duties upon several different specified classes of persons, including school teachers<sup>86</sup>, "householders"<sup>87</sup>, and managers of establishments in which food is prepared.<sup>88</sup> A common pattern followed is to require these people to notify public

<sup>&</sup>lt;sup>84</sup> In such cases, other legal remedies may be available to a person who suffers harm as a result of a report based on malice or unreasonable grounds. These would include actions for defamation, injurious falsehood and intentional infliction of emotional distress. It must be borne in mind, however, that any monetary compensation awarded in such actions may only go a small way towards redressing the harm suffered.

<sup>&</sup>lt;sup>85</sup> <u>Public Health Protection Act</u>, <u>supra</u>, note 67, s.5.

<sup>&</sup>lt;sup>86</sup> Nova Scotia <u>Health Act</u>, <u>supra</u>, note 67, s.71.

<sup>87</sup> British Columbia <u>Health Act</u>, <u>supra</u>, note 58, ss.85 & 88.

<sup>&</sup>lt;sup>88</sup> Saskatchewan <u>Regulations Governing Control and</u> <u>Notification of Communicable Disease, supra</u>, note 67, s.3.

health authorities if they become aware of any case of the reportable disease in the school, household or other institution, respectively.

In the case of HIV/AIDS, one can certainly question what public health purpose is served by imposing reporting duties that relate to such specific persons or places. The intention behind these duties was presumably to apprehend the spread of communicable diseases within households and other institutions where close contact with an infected person presented a risk of transmission. However, as it has been well-established that casual contact does not present any significant risk of transmission of HIV<sup>89</sup>, the rationale behind extending the reporting duty imposed on persons such as householders and school teachers to include cases of AIDS or HIV infection is difficult to fathom.

While these specific reporting duties cause concern, there is equal reason to be concerned about the generality of the reporting duties in some of the other provinces. In three provinces - British Columbia, New Brunswick and Prince Edward Island - and in the Yukon and the Northwest Territories, the relevant public health legislation provides

<sup>&</sup>lt;sup>89</sup> G.H.Friedland & R.S.Klein, "Transmission of the Human Immunodeficiency Virus", (1987) 317 <u>New Eng. J. Med</u>. 1125.

that every person must report cases of notifiable diseases.<sup>90</sup> This would include anyone associated with the infected person, such as relatives, friends and psychological counsellors, to name just a few.

Once again, it is hard to see what purpose is achieved by imposing a reporting duty of this nature. Even if one assumes that comprehensive case-reporting is a desirable objective, the same objective could be achieved by the use of a much more limited reporting duty, such as, for example, one applying only to physicians and testing laboratories. In view of the constitutional questions already discussed, there is a strong argument that reporting duties should be framed as narrowly as possible while still achieving the intended purpose. Reporting provisions such as those just described do not appear to meet this requirement.

#### v) To Whom must the Report be Made?

In most Canadian jurisdictions, reports of cases of AIDS or positive HIV antibody test results must be made to the local medical health officer, described variously as the "nearest" medical health officer<sup>91</sup>, the medical health

 <sup>&</sup>lt;sup>90</sup> These provisions are cited <u>supra</u>, note 67.
<sup>91</sup> Yukon <u>Communicable Diseases Regulations</u>, <u>supra</u>, note
67, s.4.

officer "having jurisdiction"<sup>92</sup> or, in the case of reports by physicians, the "medical officer of health of the health unit in which the professional services are provided".<sup>93</sup> However, some provinces require reports to be made to more than one person, such as Manitoba, where a report must be made to both the Director of Preventive Medical Services and the Director of Communicable Disease Control<sup>94</sup>, and Nova Scotia, where both the medical health officer and the Local Board of Health of the municipality must be notified.<sup>95</sup>

Two provinces - Quebec and Newfoundland - offer the alternative of reporting either to the Minister or Deputy Minister responsible for health or to the local medical health officer.<sup>96</sup> In New Brunswick, the report must be made to the nearest public health inspector who is then under a

<sup>92</sup> Saskatchewan <u>Regulations Governing Control and</u> <u>Notification of Communicable Disease</u>, <u>supra</u>, note 67, s.2(1).

<sup>93</sup> Ontario <u>Health Protection and Promotion Act</u>, <u>supra</u>, note 67, s.25.

<sup>94</sup> <u>Supra, at 40-41.</u>

<sup>95</sup> Nova Scotia <u>Regulations in Respect of the</u> <u>Communicable and Notifiable Diseases, supra</u>, note 67, s.2.

Quebec <u>Public Health Protection Act</u>, <u>supra</u>, note 67, s.5, and Newfoundland <u>Communicable Diseases Act</u>, <u>supra</u>, note 67, ss.4 & 5. duty to notify the district medical health officer immediately.<sup>97</sup>

It is clear from this that the number of persons who receive each report of a case of AIDS or HIV infection varies from province to province. This is of course an extremely important issue because of the concerns about the confidentiality of such reports. A strong argument could be made for restricting the class of persons who receive HIV/AIDS case reports as narrowly as possible, and such restrictions may indeed be necessary in order to satisfy the constitutional requirements already discussed.

## vi) The Information which must be Reported

Some provincial Public Health Acts specify what personal information, such as name, address, date of birth etc., must accompany a report of a case of a communicable or notifiable disease. In other provinces, regulations have been passed dealing with this question, while some provinces. have prescribed forms which must be used to make a report. In those provinces where there is no statutory or regulatory provision specifying the information which must be supplied,

<sup>97</sup> New Brunswick <u>General Regulation - Health Act</u>, <u>supra</u>, note 67, s.96(2).

public health authorities have stipulated, as an administrative matter, what practice must be followed.

It will be clear from this that there is little consistency between the different provinces and territories with respect to the amount of personal information about an infected person that must be supplied to public health authorities in order to comply with the applicable reporting duty. This question is important for two reasons. First, it will determine whether the information supplied is sufficient to achieve the objectives of case-reporting, or conversely, whether any of the information is irrelevant for these objectives. Second, concerns about confidentiality and discrimination on the basis of positive HIV antibody test results, and the resulting risk that compulsory casereporting will discourage people from coming forward to be tested voluntarily98, raise serious questions about the extent to which personal identifying information should be required in case-reports. The wide divergence between the various legislative provisions would seem to indicate that this question is still very much an open one in Canada.

<sup>&</sup>lt;sup>98</sup> For a more detailed discussion of this question, see <u>infra</u>, at 102-103.

## a) AIDS Case Reports

In seven of the ten Canadian provinces and the two territories, the applicable Public Health Act or regulations provide that any notification to public health authorities of a case of AIDS must include the name of the infected person. The provinces in which nominal reporting is required are British Columbia, Manitoba, New Brunswick, Newfoundland and Labrador, Nova Scotia, Ontario and Saskatchewan. These provinces and territories also require the address, the age or date of birth, and the sex of the infected person to be provided.<sup>99</sup>

Of the remaining three provinces, Alberta requires the infected person to be identified by initials rather than name<sup>100</sup>, Quebec uses a code number attached to other personal information such as age and sex<sup>101</sup>, while in Prince Edward Island, the <u>Notifiable and Communicable Diseases Regulation</u> states only that a case of AIDS must be reported "in such manner as the Chief Health Officer may direct".<sup>102</sup> The

<sup>&</sup>lt;sup>99</sup> These provisions are cited <u>supra</u>, note 67.

<sup>&</sup>lt;sup>100</sup> <u>Public Health Act</u>, <u>supra</u>, note 67, s.33, and the form prescribed pursuant to that section.

<sup>&</sup>lt;sup>101</sup> Regulations made pursuant to the <u>Public Health</u> <u>Protection Act</u>, <u>supra</u>, note 67, Schedule 13.

<sup>&</sup>lt;sup>102</sup> <u>Notifiable and Communicable Diseases Regulation</u>, <u>supra</u>, note 67, s.17.

current practice in Prince Edward Island is for reports to be made by code number.<sup>103</sup>

In other provinces, such as Ontario, there is an additional requirement that a report of a case of AIDS include details of any medical conditions indicating immunosuppression in the infected person, and of the person's "risk classification", namely evidence of the possible means of acquisition of the infection, such as whether the person is a homosexual, bisexual, intravenous drug user or has hemophilia, or is the heterosexual partner of any such person.<sup>104</sup> In view of the fact that reports in Ontario also identify the person by name, concerns about confidentiality cannot be lightly dismissed.

# b) <u>HIV Case Reports</u>

In those provinces where HIV infection is also reportable, the majority require infected persons to be reported by name.<sup>105</sup> 'The only exceptions are Prince Edward

<sup>&</sup>lt;sup>103</sup> Personal communication from Mr Charles Campbell, Deputy Minister of Health, Prince Edward Island, February 24, 1989.

<sup>&</sup>lt;sup>104</sup> O. Reg. 490/85, s.5(3).

<sup>&</sup>lt;sup>105</sup> New Brunswick, Newfoundland and Labrador, Nova Scotia, Ontario, Saskatchewan, Northwest Territories and the Yukon. The relevant provisions are cited <u>supra</u>, note 67.

Island, where the procedure for reporting "HIV antibodies" is the same as that for AIDS, and Manitoba, where positive HIV antibody test results are reportable only by virtue of a specific duty imposed upon persons in charge of a laboratory.<sup>106</sup> As the Regulations in Manitoba also require physicians submitting specimens to laboratories for HIV antibody testing to label the specimens with the person's sex and date of birth, but otherwise "in a manner which shall preserve confidentiality"<sup>107</sup>, laboratories would not generally be able to supply information identifying any person whose specimen tests positive. The practice in Manitoba is for laboratories to report positive test results by code.<sup>108</sup>

In Alberta and British Columbia, where there is no legal duty to report positive HIV antibody test results, testing laboratories nonetheless provide this data to public health authorities on a voluntary basis. These reports are non-nominal, but in British Columbia, the patient's initials, date of birth, and the name of his or her treating physician are supplied, with the aim of enabling contact-

<sup>&</sup>lt;sup>106</sup> <u>Regulation Respecting Disease and Dead Bodies</u>, <u>supra</u>, note 67, s.44.

<sup>&</sup>lt;sup>107</sup> <u>Ibid</u>., s.43(b).

<sup>&</sup>lt;sup>108</sup> Personal communication from Ms. Judy Portman, Nurse Epidemiologist, Sexually Transmitted Disease Control, AIDS Programme, Manitoba Health, January 12, 1989.

tracing to take place if it should be considered necessary.<sup>109</sup> In Quebec alone, the decision has been taken not to require the reporting of positive HIV antibody test results.

## 2) <u>Confidentiality Provisions</u>

An important aspect of the statutory framework for case-reporting in Canada is the extent to which the confidentiality of the information so gathered is given statutory protection. There will of course always be strong ethical reasons for ensuring, as a matter of principle, that personal privacy is respected. In the context of HIV/AIDS, however, there is the additional concern that the objectives sought to be achieved by case-reporting may be impeded if there are inadequate safeguards of confidentiality. This might occur either because people in high-risk groups will be discouraged from coming forward to be tested voluntarily for fear that their infected status will become widely known<sup>110</sup>, or because of non-compliance with reporting duties by physicians or others, who do not want to disclose

<sup>&</sup>lt;sup>109</sup> Personal communication from Dr Michael Rekart, Director of STD Contro!, British Columbia Ministry of Health, 31 August 1988.

<sup>&</sup>lt;sup>110</sup> There is increasing evidence of this. See <u>infra</u>, at 102-103.

information about infected persons unless there is some guarantee of confidentiality.

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It should be recognised at the outset that the problem of protecting confidentiality is a complex one that cannot easily be solved merely by the implementation of legal safeguards. One must acknowledge the practical limitations of any statutory duty of confidentiality in terms of preventing actual disclosure of information.<sup>111</sup> Nonetheless, the existence or otherwise of legal duties of confidentiality may well have some impact upon the spread of information, and may also be important on a symbolic level, as a statement of the principle that personal information about infected persons should never be disclosed unless and only to the extent that there is a justification for doing so.

An examination of Canadian public health legislation does not reveal evidence of an overwhelming concern to protect the confidentiality of personal information reported to public health officials pursuant to disease-reporting duties. One can speculate about the reasons for this. To some extent, there may be historical explanations arising from a lesser sensitivity to individual rights at the time

<sup>&</sup>lt;sup>111</sup> In this regard, see B.M.Dickens, "Legal Limits of AIDS Confidentiality", (1988) 259 <u>J.A.M.A</u>. 3449.

the legislation was drafted. Further, in recent times, the difficulties of limiting the spread of information have become more acute because of the increasing use of centralised and computerised information storage systems. At the time much of the legislation was introduced, many of the diseases which were then nctifiable had obvious outward clinical manifestations such that a person's infected status would most probably have been widely known in any event. In those cases where the disease was not apparent but still highly contagious, the desirability of imposing isolation and quarantine measures in order to prevent further contagion, may perhaps have been considered sufficient reason to override the privacy interests of the infected person.

There are however obvious objections to this hypothesis, most notably the case of venereal disease, which is neither highly contagious nor always readily apparent. Again, one can speculate that the absence in many jurisdictions of legal safeguards protecting the privacy of persons with venereal disease may reflect certain moral judgments about the forms of behaviour thought to cause a person to become infected, and a resulting lack of concern about that person's reputation and right to privacy. If this is so, the analogy with HIV/AIDS is a disturbing one, because of the potential in the present case for the moral

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censure of those groups, namely homosexual men and intravenous drug users, that have so far been primarily affected by the virus.

Five Canadian provinces - Alberta, Manitoba, Ontario, Quebec and Prince Edward Island - have provisions in their Public Health Acts or regulations which impose a duty of confidentiality on public health officials with respect to information received by them either in the course of their duties generally or which relates specifically to a person infected with a notifiable or communicable disease.<sup>112</sup> In New Brunswick, the <u>Health Act</u> provides that information received by officers of the Department of Health "in connection with research or studies relating to morbidity, mortality or the cause, prevention, treatment or incidence of disease ... shall be privileged and shall not be

<sup>&</sup>lt;sup>112</sup> Alberta <u>Public Health Act</u>, <u>supra</u>, note 67, s.63(1); Manitoba <u>Regulation Respecting Diseases and Dead Bodies</u>, <u>supra</u>, note 67, s.48; Ontario <u>Health Protection and Promotion</u> <u>Act</u>, <u>supra</u>, note 67, s.38; <u>Quebec Public Health Protection</u> <u>Act</u>, <u>supra</u>, note 67, s.7; and Prince Edward Island <u>Public</u> <u>Health Act</u>, R.S.P.E.I. 1974, c.P-29.1, s22(1).

admissible in evidence ...".<sup>113</sup> This provision might protect information received by public health officials for disease surveillance purposes, but it is doubtful whether it would apply to information about an infected person supplied to the Department in order to facilitate specific disease control measures against that person or his or her contacts, as this information would not have been received "in connection with research or studies".

In those provinces where a statutory duty of confidentiality does exist, however, all provinces except Quebec also have specific exceptions which permit the confidential information to be divulged in certain circumstances. The broadest of these exceptions is perhaps in Prince Edward Island where the Chief Health Officer may direct that information relating to a particular person be disclosed with the 1 son's consent or "in the best interest of that person or the public".<sup>114</sup> A similar exception exists in Ontario where the disclosure is made "for the purposes of

<sup>114</sup> <u>Public Health Act, supra</u>, note 67, s.22(2).

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<sup>113</sup> <u>Health Act</u>, R.S.N.B. 1973, c.H-2, s.33(1). It should also be noted in passing that this statutory provision appears to confuse the notion of privilege with that of the admissibility of evidence. If the information is "privileged", this would mean that the person in whom the privilege is vested could choose to waive the privilege. However, if the information is inadmissible in evidence, even an express waiver of privilege would not permit it to be used as evidence in court. The provision in New Brunswick is ambiguous in this respect.

public health administration".<sup>115</sup> In Alberta, although information about a person infected with a communicable disease is normally protected from disclosure "in any manner that would be detrimental to the personal interest, reputation or privacy of that person", it may be disclosed to any person "with the written consent of the Minister [of Health], where in his opinion it is in the public interest that the information be disclosed to that person."116 Ιn Manitoba, information acquired by health officials pursuant to the division of the regulations dealing with sexually transmitted diseases (which includes reporting provisions relating to AIDS and HIV) must not be disclosed "except to other persons engaged in the performance of duties under this division to the extent necessary to fulfill such duties" or "upon the written instruction of the minister". 117

These exceptions are sufficiently broad to permit the disclosure of information about persons infected with HIV in a wide variety of different circumstances. It might be possible, for example, to justify disclosing the fact of a person's infection to contacts of that person in the

<sup>116</sup> <u>Public Health Act, supra</u>, note 67, s.63(5)(b).

<sup>&</sup>lt;sup>115</sup> <u>Health Protection and Promotion Act, supra, note</u> 67, s.38.

<sup>&</sup>lt;sup>117</sup> <u>Regulation Respecting Diseases and Dead Bodies</u>, <u>supra</u>, note 67, s.48.

interests of "public health administration" in order to counsel those people about how to avoid further transmission of the virus. Similarly, if there were evidence that an infected person was continuing to engage in high-risk activities - such as, for example, an HIV antibody positive prostitute who continued to work without using condoms health officials might be permitted to release the person's name on the basis that this was necessary to protect the interests of the public. The wide discretion that these provisions give to public health officials to override the duty of confidentiality means that there can be little certainty about the extent to which any personal information supplied will be protected by the legislation.

There are, moreover, a number of provinces where the public health legislation offers no confidentiality protection for information supplied pursuant to the diseasereporting provisions. In this regard, there are some statutory anomalies. In British Columbia, for example, the <u>Health Act Communicable Disease Regulation</u> limits the class of persons to whom the results of a complsory medical examination under the Regulation can be disclosed<sup>118</sup>, but is silent in relation to other information supplied to health officials. Interestingly, the Nova Scotia <u>Health Act</u> has

<sup>118</sup> <u>Supra</u>, note 67, s.12(6).

privacy provisions relating to reports of venereal disease<sup>119</sup> and cancer<sup>120</sup> but not in relation to other notifiable diseases.

In addition to statutory protections of confidentiality, there may be common law remedies that could be invoked in the event of an unwarranted disclosure of personal information, such as actions for defamation or in negligence.<sup>121</sup> Where these common law causes of action overlap with the statutory provisions, there may be a question as to whether the statutory provisions are merely declarative of existing common law duties or whether, in some instances, they may even abrogate those duties. In any event, even if the elements necessary to establish these common law causes of action can be proved, compensation in the form of damages may not be a satisfactory remedy for persons affected by the disclosure. Moreover, some provincial public health legislation includes a provision protecting public health officers from liability with respect to anything done in good faith under the provision

<sup>&</sup>lt;sup>119</sup> <u>Health Act</u>, R.S.N.S. 1967, c.247, s.97.

<sup>&</sup>lt;sup>120</sup> <u>Ibid.</u>, s.102(2).

<sup>&</sup>lt;sup>121</sup> See, generally, S.Rodgers-Magnet, "Common Law Remedies for Disclosure of Confidential Medical Information", in <u>Report of the Royal Commission of Inquiry into the</u> <u>Confidentiality of Health Records in Ontario</u>, 1978, Appendiz I.

of the Act or regulations<sup>122</sup>, thus providing a possible defence to any claim at common law.<sup>123</sup>

The only conclusion that can be drawn from this is that the question of confidentiality remains a serious problem in this context. Although it is difficult to assess the extent to which this may encourage non-compliance with reporting duties, there is some evidence to suggest that fewer people undergo voluntary testing for HIV antibodies when the test results are reportable than when they are not.<sup>124</sup> This evidence, which will be discussed at greater length in the following chapter, would seem to indicate that concerns about confidentiality are not illusory and may well be impeding the objectives sought to be achieved by compulsory case-reporting.

<sup>124</sup> See <u>infra</u>, at 102-103.

<sup>&</sup>lt;sup>122</sup> For example, the Prince Edward Island <u>Notifiable</u> and <u>Communicable Diseases Regulations</u>, <u>supra</u>, note 67, s.15., and the Alberta <u>Public Health Act</u>, <u>supra</u>, note 67, s.68.

<sup>&</sup>lt;sup>123</sup> There would be a question in this regard as to whether the breach of confidentiality should in fact be construed as something done under the provisions of the Act. However, there would be some circumstances in which this would be clearly the case, such as, for example, if the breach of confidentiality was necessary in order to comply with a statutory duty to undertake contact-tracing.
## 3) Non-Compliance

These questions lead in turn to a consideration of the consequences of a failure to comply with case-reporting duties. This issue has become an extremely controversial one, both in Canada and elsewhere, with some physicians openly refusing to comply with HIV/AIDS reporting provisions either because of a desire to preserve the confidential nature of the physician/patient relationship or because of concerns of some actual detriment to the particular patient if the case is reported.<sup>125</sup>

These problems are not new ones. The history of opposition by physicians and others to compulsory disease reporting provisions, particularly those relating to venereal disease, has been well-documented.<sup>126</sup> However, the concern about discrimination against persons infected with HIV has highlighted this dilemma, raising the question of whether, in some circumstances, non-compliance with reporting provisions may be ethically justified, and even desirable.

<sup>126</sup> Fox, <u>supra</u>, note 67, at 13-14.

<sup>&</sup>lt;sup>125</sup> See, for example, W.King, "Doctors Cite Stigma of AIDS in Declining to Report Cases", <u>New York Times</u> 27 May, 1986, at 1.

#### i) Statutory Offences

So far as the legislative provisions are concerned, the consequences of failing to comply with a duty to report a case of a communicable or notifiable disease are generally quite clear. All the provincial Public Health Acts contain provisions specifying what penalty should be imposed in the event of a breach of the Act or of regulations made under the Act. The penalties vary, largely depending upon when the particular Act was drafted. Saskatchewan and Newfoundland have the most lenient penalties - a fine of not more than  $100^{127}$  - while in other provinces, the fine can be up to \$5,000 for repeated offences.<sup>128</sup> In some cases, a penalty can be imposed for each day that the non-compliance continues.<sup>129</sup> A number of provinces authorise the imposition of both a fine and a period of imprisonment of up to six months.<sup>130</sup> In all cases, of course, the officials administering the relevant Act retain a discretion as to whether or not they will seek to prosecute a person who

- <sup>128</sup> Alberta <u>Public Health Act</u>, <u>supra</u>, note 67, s.81(3).
- <sup>129</sup> British Columbia <u>Health Act</u>, <u>supra</u> note 58, s.113.
- <sup>130</sup> British Columbia <u>Health Act</u>, <u>Ibid</u>., s.112; and Prince Edward Island <u>Public Health Act</u>, <u>supra</u>, note 67, s.20.

<sup>&</sup>lt;sup>127</sup> Saskatchewan <u>Regulations Governing the Control and</u> <u>Notification of Communicable Disease, supra</u>, note 67, s.13, and Newfoun land <u>Communicable Diseases Act</u>, <u>supra</u>, note 67, s.34.

fails to comply with the relevant statutory duties.

The statutory provisions make it clear that when a person on whom a statutory duty to report is imposed is in possession of information required to be reported in circumstances which trigger the duty to report, failure to do so can result in a prosecution and conviction under the relevant Public Health Act. Although this statement of the principle seems somewhat convoluted, it is important to bear in mind all the elements which must be established in order to prove the offence. This will not necessarily be easy, particularly in those cases where the duty is to report a "suspicion" or "belief" that a person is infected, such that evidence from the person charged to the effect that, subjectively, he or she did not so suspect or believe may be sufficient to constitute a complete defence. With reporting provisions such as these, a successful prosecution for noncompliance, although theoretically available, may be practically impossible.

#### ii) <u>Defences</u>

Despite these evidentiary hurdles, however, there will inevitably be cases where it can be established that a person has knowingly failed to comply with case-reporting provisions. One obvious example of this would be a

physician whose own patient records indicate that he or she has been treating a patient with AIDS but who has not given the requisite notification. Are there any arguments that could be raised by the physician in order to defend a prosecution under the Act for failing to comply with the legal reporting duty?

The arguments put forward by those opposed to compulsory case-reporting have already been mentioned; it is suggested, first, that reporting duties erode the confidential nature of the physician/patient relationship, and second, that disclosure of the information may cause harm to the infected person.<sup>131</sup> The first argument is in the nature of a policy argument relating to reporting duties generally. In the face of an express statutory reporting provision, however, this argument is unlikely to provide a legal defence to a prosecution for non-compliance, as the statutory provision, by its very nature, rejects the claim that the interests of the physician/patient relationship are more compelling.

The second argument is a more interesting one as it relates to the welfare of the particular person about whom the report is to be made. It could be argued that the

<sup>131</sup> <u>Supra</u>, at 67.

common law defence of necessity applies in these circumstances on the basis that the failure to comply with the duty to report was necessary in order to avert a serious harm to the infected person. Such could be the case, for example, if the physician reasonably believed that the patient would commit suicide if the report were submitted to public health authorities.

It must be stressed, however, that courts have tended to apply the defence of necessity restrictively.<sup>132</sup> In the decision of the Supreme Court of Canada in <u>R</u>. v. <u>Morgentaler</u><sup>133</sup>, one of the leading cases in this field, Dickson J. stated that the defence of necessity could only justify non-compliance with the law "in cases of clear and imminent peril when compliance with the law is demonstrably impossible."<sup>134</sup> He went on to say: "No system of positive law can recognise any principle which would entitle a person to violate the law because on his view the law conflicted with some higher social value."<sup>135</sup> There are therefore three conditions which must be satisfied in order to establish the defence of necessity: the harm sought to be averted must be

- <sup>132</sup> See generally D.Stuart, <u>Canadian Criminal Law</u> (Toronto: The Carswell Company Ltd., 1982) at 420-428.
  - <sup>133</sup> (1975) 20 C.C.C. (2d) 449.
  - <sup>134</sup> <u>Ibid</u>., at 497.
  - <sup>135</sup> Ibid.

both grave and certain, it must be greater than the harm inflicted by breaking the law, and there must have been no way of avoiding this harm other than by breaking the law.

In view of this, it would seem that the defence of necessity will be of limited application in the context of non-compliance with disease reporting duties. The majority of cases in which the defence has been successful have involved the threat of serious harm to a person's life or health<sup>136</sup>, and it will rarely be possible to establish that such a threat results from compliance with the reporting duty. The case of a likely suicide is one such possibility; it would probably not be sufficient, however, if the harm sought to be averted was simply the emotional distress that would be suffered by the infected person if the report were made.

On a more far-reaching level, the prosecution of a person for failing to comply with the reporting duty could be defended on the basis that the reporting provision itself is invalid. This could be argued on the basis that the reporting provision contravenes the <u>Canadian Charter of</u> <u>Rights and Freedoms</u> or the applicable provincial human

<sup>&</sup>lt;sup>136</sup> For example, <u>R</u>. v. <u>Morris</u>, (1981) 61 C.C.C. (2d) 163 (Alta. Q.B.), and <u>R</u>. v. <u>Kennedy</u>, (1972) 7 C.C.C. (2d) 42 (N.S. Co. Ct.).

rights legislation. In particular, section 7 of the Charter, which guarantees the right to life, liberty and security of the person, and the equality provisions in section 15 may offer a remedy.<sup>137</sup>

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Secondly, it could be argued that the case-reporting provisions are ultra vires the Constitutional head of power under which they were purported to be enacted, either generally or insofar as they relate to HIV/AIDS. Although there is no direct authority on this point, it may be possible to establish that the reporting provisions constitute an invalid exercise of the public health power, if it can be shown that they are not reasonably related to any valid public health objective, and therefore are outside jurisdictional competency. This would clearly be a difficult case to make out, but the argument may be available in extreme circumstances.

The above principles relate to clear cases of noncompliance with a legal duty to report HIV/AIDS. Even more difficult questions arise, however, where a person, while purporting to comply with the strict letter of the law, seeks to avoid the obligation to report in other ways. This is a very real problem in the context of HIV/AIDS. What is

<sup>&</sup>lt;sup>137</sup> The principles that would be applied in this context were discussed in the previous chapter. See <u>supra</u>, at 22-33.

the position, for example, where anonymous HIV antibody testing services are offered by someone who deliberately omits to obtain any identifying information from persons being tested in order to avoid having to report such information to public health authorities? Does it constitute a technical compliance with the duty to report if the mere fact of an unidentified person having tested positive is reported, where the person reporting is unable to supply any further information by reason of his or her own deliberate acts? An analogous situation is where unlinked HIV antibody screening is carried out with careful steps being taken to ensure that no blood sample can be linked to any particular individual.

The answer to these questions must lie in a careful consideration of the precise wording of the reporting provision applicable in each particular case. Most of the provisions impose a duty to report certain information but have no ancillary provision imposing a duty on physicians and others to obtain that information. It could be argued that such an ancillary duty could be implied from the duty to report, but in view cf the penal provisions attaching to a failure to comply with the duty, it is likely that the duty to report would be construed narrowly according to

general principles of statutory interpretation.<sup>138</sup> Thus, if persons comply with the strict letter of the reporting duty to the best of their ability, even though the inability to comply more fully is due to their own actions, this may be sufficient to avoid liability.

# B. SOME INTERNATIONAL COMPARISONS

The above analysis of statutory reporting provisions in Canada has pointed to some of the problems associated with HIV/AIDS case-reporting as it exists in the various provinces and territories. However, the use of compulsory case-reporting is not unique to Canada; a number of other countries around the world have implemented HIV/AIDS casereporting procedures with the aim of achieving similar public health objectives. Before turning to consider the extent to which the Canadian provincial case-reporting requirements are effective in achieving those objectives, it is useful to look at some of the approaches adopted by other countries to the same issue.

<sup>138</sup> Stuart, <u>supra</u>, note 132, at 29-32.

# 1) United States

In the United States, which has by far the highest number of reported cases of AIDS and the highest number of cases per population million of any country outside Africa and the Caribbean<sup>139</sup>, legislation or regulations in all fifty states require cases of AIDS to be reported.<sup>140</sup> The definition of AIDS issued by the Centers for Disease Control in Atlanta has been adopted by all states for reporting purposes.<sup>141</sup> As in Canada, the reporting duties differ from state to state, but the relevant provisions commonly require the name, address and age of the infected person to be supplied.<sup>142</sup>

One particularly interesting feature of the reporting provisions in the United States when compared with those in Canada is that positive HIV antibody test results are reportable in only a small minority of the American states.

<sup>142</sup> <u>Ibid</u>., at 28. For a review of a number of different legislative provisions relating to the reporting of cases of AIDS in the United States, see H.E.Lewis, "Acquired Immunodeficiency Syndrome: State Legislative Activity", (1987) 258 <u>J.A.M.A</u>. 2410, at 2413-2414.

<sup>&</sup>lt;sup>139</sup> J.M.Mann et.al., "The International Epidemiology of AIDS", <u>Scientific American</u>, October 1988, 82, at 86-7.

<sup>&</sup>lt;sup>140</sup> L.Gostin & A.Ziegler, "A Review of AIDS-Related Legislative and Regulatory Policy in the United States", (1987) 15 Law, Medicine and Health Care 5, at 10.

<sup>&</sup>lt;sup>141</sup> Curran et al., <u>supra</u>, note 54, at 28-29.

Six states - Arizona, Colorado, Idaho, Montana, South Carolina and Wisconsin - specifically require positive test results to be reported, while three others have regulations which would seem to imply such a duty by requiring the reporting of any "case", "condition" or "carrier state" relating to listed diseases, which include AIDS.<sup>143</sup> Most of these states require the name of the intected person to be included in the report.<sup>144</sup>

It is difficult to ascertain whether the absence of legal reporting duties relating to HIV infection in most American states can be explained by the fact that, as in Alberta and British Columbia, information about the level of infection is obtained from testing laboratories or other sources on a voluntary basis. Whatever the reason, however, it is significant that few of the state legislatures have thought it necessary to address this question specifically in public health legislation.

# 2) <u>Australia</u>

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An interesting comparison can also be made with reporting requirements in Australia, a country where the

<sup>&</sup>lt;sup>143</sup> Gostin & Ziegler, <u>supra</u>, note 140, at 10, and Curran et al., <u>supra</u>, note 54, at 29.

<sup>&</sup>lt;sup>144</sup> Curran et al., <u>Jbid</u>.

epidemiological picture of HIV/AIDS is very similar to Canada.<sup>145</sup> Of Australia's six states and two territories, all require AJDS to be reported.<sup>146</sup> In addition, the six states require the reporting of conditions falling within Groups JIJ and IVA of the Centers for Disease Control HIV/AJDS classifications<sup>147</sup>, which cover cases of lymphadenopathy and HIV-related constitutional disease, such as fever and night sweats. For the purposes of AIDS casereporting, the Centers for Disease Control definition is used consistently across the country.<sup>148</sup>

Positive HIV antibody test results are reportable in three states - New South Wales, Queensland and Western Australia - and in the Northern Territory. Legislation making HIV infection reportable was passed by the Victorian Parliament in 1986 but has never been proclaimed.<sup>149</sup>

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<sup>149</sup> Whyte & Cooper, <u>supra</u>, note 146, at 18.

<sup>&</sup>lt;sup>145</sup> N.Gilmore, "Human Immunodeficiency Virus Transmission and its Impact in Canada", in Australian Government Publishing Service, <u>Report on the 3rd National</u> <u>Conference on AIDS, 4-6 August, 1988</u>, (Canberra, 1988), 84, at 84.

<sup>&</sup>lt;sup>146</sup> B.M.Whyte & D.A.Cooper, "Surveillance of Infection with Human Immunodeficiency Virus Type 1 in Australia - A Model for International Development", unpublished manuscript, November 1988, at.18.

<sup>&</sup>lt;sup>147</sup> Ibid.

<sup>&</sup>lt;sup>148</sup> Personal communication from Dr. Bruce Whyte, National Health and Medical Research Council Special Unit in AIDS Epidemiology and Clinical Research, Sydney, Australia.

So far as the mode of reporting is concerned, the provisions in New South Wales and Victoria merit closer These two states together account for over attention. eighty per cent of known cases of HIV infection in Australia.<sup>150</sup> In New South Wales, where both AIDS and HIV infection are "proclaimed diseases", a duty is imposed upon medical practitioners to report all cases of a proclaimed disease to the state Department of Health.<sup>151</sup> In the case of HIV/AIDS, the report must be in a special prescribed form which must include the first two initials of the patient's surname, the date of birth, the probable mode of disease transmission and the name of any testing laboratory where a HIV antibody test has been carried out. The medical practitioner is also required to state "Action Taken", such as whether the patient has been counselled about sexual practices or drug use or provided with information as to support services available.<sup>152</sup>

In addition to submitting the prescribed form, medical practitioners are required to keep a record of particulars

<sup>&</sup>lt;sup>150</sup> <u>Ibid.</u>, at 19.

<sup>&</sup>lt;sup>151</sup> <u>Public Health (Proclaimed Diseases) Amendment Act</u> (New South Wales), 1985, s.50H(3).

<sup>&</sup>lt;sup>152</sup> <u>Public Health Regulations</u> (New South Wa'es), s.34E(1)(c) & Schedule 13C.

of each patient which must include "all particulars supplied to the practitioner as to the name, address, age, sex and occupation of the patient or person", and details of any diagnostic tests carried out.<sup>153</sup> The wording of this provision would seem to indicate that medical practitioners need only record information volunteered by the patient and do not have a positive duty to compile a comprehensive record of particulars about each patient. It is an offence under the Act for a doctor to disclose the name or address of the patient when submitting the reporting form to the Department of Health.<sup>154</sup> However, this information must be supplied if the Chief Health Officer of the Department serves the doctor with written notice requiring him or her to disclose the patient's name and address to the Department.<sup>155</sup> This is presumably to enable contact-tracing to be carried out, if it should be thought necessary.

In Victoria, cases of AIDS are notifiable by name pursuant to the <u>Diseases Notification Regulations, 1984</u>.<sup>156</sup>

<sup>&</sup>lt;sup>153</sup> <u>Public Health (Proclaimed Diseases) Amendment Act.</u>, s.50H(1), and <u>Public Health Regulations</u>, s.34E(1)(a).

<sup>&</sup>lt;sup>154</sup> <u>Public Health (Proclaimed Diseases) Amendment Act</u>, s.50I.

<sup>&</sup>lt;sup>155</sup> <u>Ibid.</u>, s.50K.

<sup>&</sup>lt;sup>156</sup> Commonwealth Department of Health, <u>Australia's</u> <u>Response to AIDS</u>, (Canberra: Australian Government Publishing Service, 1986), at 27.

The most interesting feature of the Victorian legislative framework for the purposes of the present discussion, however, is the recent <u>Health (General Amendment)</u> <u>Act,1988<sup>157</sup></u>, which adopts an unusual approach to the problem of how best to collect data on the incidence and prevalence of HIV infection. Rather than making HIV antibody positive test results reportable on a case-by-case basis, the Act instead imposes a duty on persons in charge of testing laboratories to submit regular written records to the Department of Health supplying, as far as possible, the following information:

- the number of HIV antibody tests carried out during a certain period;
- the number of persons tested who fall into each prescribed category of behaviour;
- the number of persons newly diagnosed as infected with HIV who fall into each category of behaviour:
- the age, sex and category of behaviour of each newly diagnosed person; and
- the date the specimen was taken from each newly diagnosed person. 158

Under this provision, epidemiological data on the incidence and prevalence of HIV infection can be collected in aggregate in a way that should not enable any of the information to be linked to a particular individual tested. While the Act requires medical practitioners to cooperate in assisting laboratories to collect this information, they are

<sup>&</sup>lt;sup>157</sup> This Act was passed by the Victorian Parliament in 1988 but has not yet been proclaimed.

<sup>&</sup>lt;sup>158</sup> <u>Health (General Amendment) Act</u>, 1938 (Victoria), s.130.

expressly prohibited from supplying information to the laboratory which would identify the person whose blood is being tested.<sup>159</sup>

# 3) United Kingdom

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A third country which provides a useful comparison in this context is the United Kingdom. In 1985, the British Parliament considered whether to make AIDS a notifiable disease under the <u>Public Health Act, 1984</u>.<sup>160</sup> If so designated, all sections of the Act would have applied to AIDS, including such outdated provisions as those prohibiting infected persons from travelling on public transport. A Parliamentary Committee considering the question concluded that it would not be desirable to amend the Act to make AIDS notifiable, because this would not be of any use in controlling the spread of HIV infection and might deter people from being tested.<sup>161</sup> Legislation was passed to make the sections of the <u>Public Health Act</u> relating to mandatory medical examinations, the detention of

<sup>&</sup>lt;sup>159</sup> <u>Ibid.</u>, s.130(4) and (5).

<sup>&</sup>lt;sup>160</sup> R, Elsbury, "AIDS Quarantine in England and the United States", (1986) 10 <u>Hastings International and</u> <u>Comparative Law Review</u> 113, at 141.

<sup>&</sup>lt;sup>161</sup> Social Services Committee, <u>Problems Associated with</u> <u>AIDS</u>, Third Report, vol. 1, Session 1986-87, 13 May 1987, as cited in Mackinnon & Krever, <u>supra</u>, note 21, at 358.

persons in hospitals, and the removal and disposal of corpses specifically applicable to cases of AIDS, but no system of compulsory case-reporting was implemented.<sup>162</sup>

This does not mean that public health authorities in the United Kingdom are without any information about the incidence and prevalence of AIDS and HIV infection. In practice, information of this nature is supplied to local health boards by medical practitioners and testing laboratories on a voluntary and informal basis. However, there is no systematic and centralised compilation of data on infected persons.<sup>163</sup>

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<sup>&</sup>lt;sup>162</sup> Elsbury, <u>supra</u>, note 160, at 141.

<sup>&</sup>lt;sup>163</sup> Personal communication from Dr. Anne Johnson, Senior Lecturer, Academic Department of Genito-Urinary Medicine, University College & Middlesex School of Medicine, December 2, 1988.

#### IV. USES OF COMPULSORY CASE-REPORTING

One of the most striking features to emerge from an examination of case-repo ting requirements in Canadian jurisdictions and elsewhere is the enormous variety in the nature and scope of the different requirements. Whether one looks at the amount of information that must be reported, the circumstances which give rise to a duty to report or the class of people who are required to report, there is little or no uniformity between the various reporting duties. Although the countries studied all display a similar pattern of HIV infection<sup>164</sup>, they have adopted very different approaches towards compulsory HIV/AIDS case-reporting.

What do these differences say about the role of compulsory case-reporting in the context of HIV/AIDS? If there were a clear consensus about how best to use casereporting to maximise the effects of our efforts to reduce the spread of HIV, it seems reasonable to assume that this consensus would have been reflected in the implementation of uniform reporting requirements in the jurisdictions studied. Instead, however, there seems to be a widespread difference

<sup>164</sup> J.M.Mann, <u>supra</u>, note 139, at 84.

of opinion as to what form the reporting requirements should take. Are there any good reasons for the different approaches that have been adopted, or are the differences simply indicative of a general uncertainty about how casereporting can be effectively utilised for public health purposes?

In order to answer this question, it is necessary to examine more closely the stated objectives of compulsory case-reporting and to consider both the extent to which these objectives are achieved and whether some of the existing provisions are more effective than others in this regard. Only then can one decide whether the potential harms of case-reporting and the resources invested in maintaining the case-reporting system can be justified by the resulting public health benefits. An analysis of this nature is important not only to guide an effective public health strategy but also to determine whether public health measures such as compulsory case-reporting are likely to be able to withstand a constitutional challenge under the Canadian Charter of Rights and Freedoms.<sup>165</sup>

The objectives sought to be achieved by compulsory case-reporting can be said to fall into two broad

<sup>&</sup>lt;sup>165</sup> See <u>supra</u>, at 28-33.

categories. In the first place, it is said that casereporting is necessary to obtain important epidemiological data about the incidence and prevalence of a particular disease. Secondly, it is argued that the keeping of a register of the names of all infected persons enables public health officials to implement programs or strategies directed specifically at infected persons to reduce the risk of the disease spreading beyond those persons already infected. At one extreme, these programs or strategies could involve isolating infected persons from the rest of the population. Less intrusive measures include counselling infected persons about measures to be adopted to reduce the risk of spreading the disease and tracing the contacts of infected persons so that they can be informed of the possibility that they have been exposed to the disease and take steps not to spread the infection further.

In the case of HIV/AIDS, the possibility of isolating all persons infected with HIV (although seriously suggested by some<sup>166</sup>) is not a realistic one given financial constraints and the unacceptable deprivation of the liberty of people who pose no danger to others through casual

<sup>&</sup>lt;sup>166</sup> Some such proposals are discussed in D.Altman, <u>AIDS</u> <u>in the Mind of America</u>, (New York: Anchor Press, 1987), at 63-68, and D.P.Francis & J.Chin, "The Prevention of Acquired Immunodeficiency Syndrome in the United States", (1987) 257 <u>J.A.M.A.</u> 1357, at 1363.

contact.<sup>167</sup> There may perhaps be some rational basis for isolating those infected persons who knowingly continue to put other persons at risk of infection<sup>168</sup>, but such a measure, even if justified, would be based not so much on a case-reporting system which enabled the identification of all infected persons as on some procedure for identifying which infected persons were actually posing a risk to others. The question of some form of "behaviour-linked" quarantine is therefore beyond the immediate scope of this study.

One can therefore conclude that the relevant public health objectives that could be achieved by compulsory casereporting of HIV/AIDS are essentially those of obtaining epidemiological data, cf ensuring that infected persons receive appropriate counselling about measures to reduce transmission, and of implementing some form of statesupervised contact-tracing. In evaluating whether compulsory case-reporting is a necessary pre-requisite for achieving these objectives, and if so, what form of case-

<sup>168</sup> See, in particular, Macklin, <u>Ibid</u>., at 21.

<sup>&</sup>lt;sup>167</sup> For a more detailed discussion of these arguments, see L.Gostin & W.J.Curran, "Legal Control Measures for AIDS Reporting Requirements, Surveillance, Quarantine, and Regulation of Public Meeting Places, (1987) 77 <u>A.J.P.H.</u> 214, at 216-7; R.Macklin, "Predicting Dangerousness and the Public Health Response to AIDS", (1986) 16 <u>Hastings Center Report</u> 16; Parmet, <u>supra</u>, note 5; and Elsbury, <u>supra</u>, note 160.

reporting is most effective, it is proposed to consider each of the objectives in turn.

# A. EPIDEMIOLOGICAL OBJECTIVES

# 1) Why is Epidemiological Data Needed?

The unchallenged aim of gathering epidemiological data about HIV/AIDS is to be able to monitor the incidence and prevalence of the disease and thereby to obtain data relevant for prevention or control measures.<sup>169</sup> It has been said that surveillance of cases of AIDS has in fact formed the foundation of our current understanding of the disease<sup>170</sup>, as only by following the natural history of the disease was it possible to determine methods and patterns of transmission. Similarly, the surveillance of cases of HIV infection provides the basis for projections about AIDS cases in the future and indicators of how and through which populations the infection is spreading today.<sup>171</sup>

<sup>&</sup>lt;sup>169</sup> Francis & Chin, <u>supra</u>, note 166, at 1362.

<sup>&</sup>lt;sup>170</sup> Ibid.

<sup>&</sup>lt;sup>171</sup> <u>Ibid</u>., at 1362-1363; J.R.Allen & J.W.Curran, "Prevention of AIDS and HIV Infection: Needs and Priorities for Epidemiologic Research", (1988) 78 <u>A.J.P.H</u>. 381, at 381; and Whyte & Cooper, <u>supra</u>, note 146, at 8.

These projections are important for a number of reasons. Accurate predictions about the future prevalence of AIDS and HIV infection are necessary for health care planning to provide rescurces and facilities for the care and treatment of infected persons.<sup>172</sup> These predictions also enable prevention efforts, such as education programmes and the provision of condoms and clean needles, to be targeted specifically towards those population groups who are at high risk of infection.<sup>173</sup> If it is not known how the infection is spreading, it is not possible to identify the risk factors and direct intervention programmes accordingly.

Knowledge about the pattern of HIV infection is also important for evaluating the effectiveness of prevention measures that have already been implemented.<sup>174</sup> This has been particularly important, for example, in determining the extent to which homosexual men have adopted lifestyle changes in response to HIV/AIDS, and in identifying intravenous drug users as one of the groups that does not yet appear to have adopted sufficient precautions to reduce

- <sup>173</sup> Allen & Curran, <u>supra</u>, note 171, at 384.
- <sup>174</sup> Whyte & Cooper, <u>supra</u>, note 146, at 8.

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<sup>&</sup>lt;sup>172</sup> Curran et al., <u>supra</u>, note 54, at 28; and Whyte & Cooper, <u>supra</u>, note 146, at 8.

the spread of the virus.<sup>175</sup> This information, in turn, enables more effective prevention measures to be taken in the future.

Finally, surveillance data about AIDS and HIV infection may be important in the future in order to determine the efficacy of therapeutic measures, particularly in the case of a potential vaccine if one should become available.<sup>176</sup>

# 2) What Data is Needed?

For the purposes just described, relevant data would be that which assists in identifying risk factors and trends in the pattern of HIV infection.<sup>177</sup> There can be no doubt that names and other personal identifiers are of no epidemiological use in this context. However, information about how a person contracted the infection (described variously as that person's "risk activity" or "risk classification") is important, as is demographic information about a person's age, sex and geographic location.<sup>178</sup> If the

- <sup>176</sup> Whyte & Cooper, <u>supra</u>, note 146, at 8.
- Allen & Curran, supra, note 171, at 384.

<sup>&</sup>lt;sup>175</sup> Centers for Disease Control, "Human Immunodeficiency Virus Infection in the United States: A Review of Current Knowledge", (1987) 36 <u>M.M.W.R</u>. (suppl. no. S-6), at 2.

<sup>&</sup>lt;sup>178</sup> See, generally, Centers for Disease Control, <u>supra</u>, note 175.

data is obtained in circumstances which raise concern about a possible duplication of positive HIV antibody test results, it may also be desirable to obtain details of the person's previous testing history in order to permit an accurate statistical adjustment of the data.<sup>179</sup>

It is important to note that even where the data obtained is limited, such as where only age, sex, geographic location and risk classification are recorded, the anonymity of infected persons cannot always be assured. In smaller communities, for example, the number of persons of a particular age and sex may be sufficiently small to enable someone who knows that community to identify with a reasonable degree of certainty the person to whom a particular set of data relates. In any event, the data set may be specific enough to generate rumours and suspicion about who may be infected.

One possible solution to this is to generate the data in an aggregate form, so that for a certain group of persons who test positive, data is available indicating only what percentage of that group is of a particular age, sex or risk classification; data sets relating to each specific infected

<sup>&</sup>lt;sup>179</sup> See, for example, the proposal for laboratory-based surveillance described in Whyte & Cooper, <u>supra</u>, note 146, at 11.

individual would not be kept. For epidemiological purposes, data generated in this form can be just as useful as more specific data and is considerably less likely to result in breaches of confidentiality. A good example of this model of data collection can be found in the Victorian <u>Health</u> <u>(General Amendment) Act, 1988</u>.<sup>180</sup>

# 3) Epidemiological Value of Compulsory AIDS Case-Reporting

The argument in favour of compulsory case-reporting for epidemiological purposes is strongest when one looks at requirements for reporting clinical AIDS. A diagnosis of AIDS can be made with a high degree of certainty and consistency.<sup>181</sup> Moreover, on the issumption that all persons suffering from AIDS will eventually seek medical treatment, an AIDS case-reporting duty imposed upon physicians (providing the duty is complied with) could be expected to result in reliable and accurate data about the incidence and prevalence of the disease.

<sup>180</sup> <u>Supra</u>, at 80-82.

<sup>181</sup> Curran et al., <u>supra</u>, note 54, at 29.

Even if one accepts, however, that compulsory AIDS case-reporting can be justified on epidemiological grounds, some comments need to be made about the form this reporting should take in order to fulfil its epidemiological objective. In the first place, it is clearly imperative that there be consistency in the case definition of AIDS used for reporting purposes.<sup>182</sup> As has already been shown, there is no such consistency within Canada or between Canada and the other jurisdictions studied.<sup>183</sup> Unless these differences are taken into account when compiling national or international data, the epidemiological picture could be seriously distorted because of the discrepancies between the different reporting requirements.

Secondly, the accuracy of the data obtained will be compromised if there is duplication in reporting, that is, if information about any one person with AIDS is provided to public health authorities from more than one source. There are a number of ways of guarding against this. Unfortunately, the simplest way is to require nominal reporting, but because of the risk this poses to the infected person and as nominal reporting serves no other useful epidemiological purpose, there is a strong argument

<sup>182</sup> Ibid.

<sup>183</sup> <u>Supra</u>, at 42-26.

that nominal reporting, if intended only to avoid duplication, cannot be justified. Other, less harmful, ways of reducing duplication include limiting the class of persons who are under a duty to report (as in Quebec, for example, where only physicians are subject to a reporting duty<sup>184</sup>), and requesting additional information, such as a person's previous HIV antibody testing history, to assist in the detection of duplicate reports.<sup>185</sup> Precautions such as these are notably absent from AIDS reporting provisions in Canada, leading to further concern about the epidemiological value of the data so collected.

Thirdly, it is evident that most of the AIDS reporting provisions in Canada go beyond what is required purely for epidemiological purposes. The most obvious example of this is the requirement in seven of the Canadian provinces that reports of AIDS include the name and address of the infected person.<sup>186</sup> Apart from the problem of duplication already discussed, this information is of no epidemiological significance and may lead to significant intrusions upon the privacy of infected persons. Other examples of unnecessarily broad reporting requirements are those

<sup>184</sup> <u>Supra</u>, at 49.
<sup>185</sup> <u>Supra</u>, at 91.
<sup>186</sup> <u>Supra</u>, at 55.

provisions which require the reporting of a mere suspicion or belief that a person is infected<sup>187</sup>, or which impose a reporting duty on every member of the population and not just those who are medically-qualified to make a diagnosis.<sup>188</sup> In both cases, the data obtained would be too unreliable to be of any real epidemiological value.

These factors clearly raise the question of whether the compulsory AIDS reporting requirements that currently exist in Canada can legitimately be justified on the basis that they serve a necessary epidemiological objective. This is not to suggest that such requirements can never be justified on epidemiological grounds, or even that the data actually collected in Canada to date is of no epidemiological value.<sup>109</sup> When evaluating the existing legal requirements, however, it is necessary to acknowledge that they are not carefully tailored so as best to achieve the relevant epidemiological objectives, and that, in many cases, they encroach upon individual rights more than is necessary for achieving those objectives. Given the ever-present

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<sup>&</sup>lt;sup>187</sup> For example, in New Brunswick and Saskatchewan, <u>supra</u>, at 47-48.

<sup>&</sup>lt;sup>188</sup> For example, in British Columbia and Prince Edward Island, <u>supra</u>, at 50-51.

<sup>&</sup>lt;sup>189</sup> In fact, there is evidence to suggest that the actual practice of AIDS case-reporting may differ markedly from the strict legal requirements.

possibility of a challenge to the AIDS case-reporting provisions under the <u>Charter</u>, these conclusions must raise doubts about whether many of the provisions could survive such a challenge, at least insofar as their validity depends upon their having sufficient and necessary epidemiological value.

# 4) Epidemiological Value of Compulsory HIV Case-Reporting

In the preceding section, the arguments in favour of compulsory case-reporting for cases of AIDS were discussed. It was concluded that properly-drafted reporting requirements could serve a valuable epidemiological purpose by providing reliable and comprehensive data about the incidence and prevalence of the disease. It is now necessary to consider whether the same arguments can be used to justify reporting duties relating to HIV seropositivity.

There can be little doubt that accurate information about the incidence and prevalence of HIV infection would be a valuable tool in guiding prevention efforts and in predicting future demands on the health care system. Because of the delay between infection with HIV and the clinical manifestations of AIDS, data about HIV infection is particularly important to obtain an early indication of infection trends. Any proposals for ways of obtaining this information clearly merit consideration, as long as they are financially viable and do not represent an unacceptable intrusion upon individual rights.

But can the compulsory case-reporting of HIV seropositivity make a worthwhile contribution in this regard? There are a number of reasons to believe that it cannot, because of the selectiveness and unreliability of any data so obtained.

The most important objection to the use of compulsory HIV case-reporting as a means of obtaining epidemiological data is that, with a few exceptions<sup>190</sup>, the process of undergoing the HIV antibody test is a self-selecting one.<sup>191</sup> In the absence of widespread mandatory testing requirements (and there are compelling policy arguments for not implementing such requirements<sup>192</sup>), any data obtained about

<sup>191</sup> Curran et al., <u>supra</u>, note 54, at 29-30.

<sup>192</sup> This issue is a highly complex one which cannot be dealt with exhaustively here, but see generally, M.A.Somerville & N.Gilmore, <u>Human Immunodeficiency Virus</u> <u>Antibody Testing in Canada</u>, McGill Centre for Medicine, Ethics

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<sup>&</sup>lt;sup>190</sup> Such as the mandatory testing for all military recruits in the United States (see Francis & Chin, <u>supra</u>, note 166, at 1363). However, even this process is self-selecting to some extent, as potential recruits have the option of withdrawing their application rather than undergoing an HIV antibody test.

persons who test positive will relate only to those persons who have voluntarily come forward to be tested. There is a growing body of evidence to suggest that this data will not present a true picture of the actual level of HIV infection within a particular population group. In one study conducted at an STD clinic in the United States, for example, the percentage of persons testing HIV antibody positive among those who underwent voluntary testing was compared with the percentage of infected persons in a programme of anonymous, unlinked testing at the same clinic. It was found that the rate of infection among those who tested voluntarily was less than one-fifth that of the clinic population generally.<sup>193</sup> Similar results were obtained in a comparable study at an obstetrics clinic in New York. 194

These results indicate that a large number of people infected with HIV are not coming forward to be tested voluntarily. Accordingly, any data about the incidence of HIV infection based on voluntary HIV antibody test results.

# and Law, January 1988.

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<sup>&</sup>lt;sup>193</sup> H.F.Hull et al., "Comparison of HIV-Antibody Prevalence in Patients Consenting to and Declining HIV-Antibody Testing in an STD Clinic", (1988) 260 J.A.M.A. 935.

<sup>&</sup>lt;sup>194</sup> R.Sperling et al., "Serosurvey of an Obstetrical Population in a Voluntary Hospital in New York City", Paper presented at the IV International Conference on AIDS, Stockholm, June 12-16, 1988.

should be approached with caution. This alone might be reason enough to question the epidemiological value of compulsory reporting of HIV seropositivity. There are, however, additional factors which further weaken the reliability of this data.

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While a diagnosis of AIDS can be made with some certainty, the same cannot always be said of HIV infection. The risk of false positive and negative results in the HIV antibody test, particularly in low prevalence populations, has been well-documented<sup>195</sup>, while more recently, it has been suggested that some persons infected with the virus may either never develop antibodies at all<sup>196</sup> or else may develop antibodies transiently.<sup>197</sup> The window period between exposure to the virus and the development of antibodies further reduces the accuracy of test results.<sup>198</sup>

<sup>196</sup> Dr. Luc Montagnier, Louis Pasteur Institute, Lecture at McGill University Faculty of Medicine, 5 January 1989.

Barry et al., <u>supra</u>, note 74.

<sup>&</sup>lt;sup>195</sup> See <u>supra</u>, note 74.

E.A. Operskalski, "Transient Anti-HIV Seropositivity", Paper presented at the IV International Conference on AIDS, Stockholm, June 12-16, 1988; and F.Montella et al., "Transitory Antibody Response to HIV Infection in Ten Patients with Various Risk Factors", Paper presented at the IV International Conference on AIDS, Stockholm, June 12-16, 1988.

There is also the question of the testing procedure used. The lack of uniformity in the legislation concerning the means by which a diagnosis of HIV infection should be made has already been discussed<sup>199</sup>, and it has been seen that there is a diversity of approaches to this question, particularly in relation to what confirmatory testing is required. As different laboratories follow different testing procedures, there is a very real problem of lack of consistency in the results obtained.<sup>200</sup>

In response to these arguments, it could be said that any data about HIV infection, however imperfect it may be, is better than no data at all. While there may be cause to doubt the accuracy of data obtained from compulsory HIV case-reporting, it still provides some evidence of the prevalence of HIV infection and allowances can be made for a margin of error. It could be argued that the magnitude of the threat of HIV/AIDS is sufficiently great to justify the use of all available sources of information.

This argument, however, does not withstand closer analysis. First, it is simply not true to say that inaccurate data is better than no data at all. If policy

<sup>&</sup>lt;sup>199</sup> <u>Supra</u>, at 44-46.

Curran et al., <u>supra</u>, note 54, at 30.

decisions concerning prevention programmes are made on the basis of test results which give a false picture of the pattern of HIV infection, there is a real risk that prevention efforts will be misdirected. Population groups at high risk of HIV infection and new or alternative routes of HIV transmission may be overlooked, and prevention measures which are implemented may not be put to maximum effect.

Secondly, the choice is not between having imperfect data or no data at all. There are a number of other sources of data about levels of HIV infection, which provide more accurate data than that obtained as a result of compulsory HIV case-reporting. These include anonymous seroprevalence surveys, the unlinked testing of certain populations and data obtained from testing programmes such as those undertaken for military recruits in both the United States and Australia.<sup>201</sup> Given the availability of alternative and better methods of data collection, one must question whether the resources used in maintaining a compulsory HIV casereporting system could not be put to a more cost-effective use.

<sup>&</sup>lt;sup>201</sup> Francis & Chin, <u>supra</u>, note 166, at 1363; and Whyte & Cooper, <u>supra</u>, note 146, at 10 and 14-17.

Thirdly, compulsory reporting of HIV seropositivity with personal identifiers may obstruct broader efforts to combat HIV/AIDS by discouraging voluntary testing. The evidence of this is increasing, with studies published in recent months showing a correlation between the introduction of reporting requirements for HIV and a decline in the number of persons seeking to undergo the HIV antibody test. In South Carolina, for example, one testing clinic reported a decline of 51% in the rate of monthly attendance by men reporting homosexual activity immediately following the introduction of a mandatory nominal reporting policy in that state.<sup>202</sup> \_n New South Wales, the introduction into Parliament of the Public Health (Proclaimed Diseases) Amendment Act<sup>203</sup> coincided with a marked drop in levels of voluntary HIV antibody testing<sup>204</sup>, and similar results were reported following the introduction of compulsory reporting

<sup>&</sup>lt;sup>202</sup> W.D.Johnson, F.S.Sy & K.L.Jackson, "The Impact of Mandatory Reporting of HIV Seropositive Persons in South Carolina", Paper presented at the IV International Conference on AIDS, Stockholm, June 12-16, 1988.

<sup>203 &</sup>lt;u>Supra</u>, note 151.

<sup>204</sup> Personal Communication from Margaret Duckett, former Specialist Advisor on AIDS, Australian Department of Community Services and Health.
in Colorado.<sup>205</sup> Surveys conducted at other testing sites and among specific population groups have also shown evidence of a greater reluctance to undergo voluntary testing when positive test results are reported to public health authorities on a nominal basis or by code than when there are no reporting requirements for HIV seropositivity.<sup>206</sup>

The conclusion to be drawn from this is that not only may compulsory HIV case-reporting fail to provide meaningful epidemiological data, it may also actually hinder efforts to reduce the spread of HIV. If the epidemiological benefits of a compulsory HIV reporting policy were great, it might be possible to argue that the risk of these other harms is worth taking. However, given the doubtful value of the data obtained, it becomes increasingly difficult to justify compulsory HIV case-reporting from an epidemiological point

<sup>&</sup>lt;sup>205</sup> Curran et al., <u>supra</u>, note 54, at 30. These conclusions, however, are not undisputed. See F.N.Judson, F.C.Wolf & D.L.Cohn, "HIV Testing and Counseling Activity in Colorado: Effects of Reporting Results by Name", Paper presented at the IV International Conference on AIDS, Stockholm, June 12-16, 1988.

<sup>&</sup>lt;sup>206</sup> G.Ohi et al., "Change in Acceptance Rate for HIV Testing when AIDS is Notifiable", Paper presented at the IV International Conference on AIDS, Stockholm, June 12-16, 1988; and B.Lo, S.Meacham & N.Milliken, "AIDS Screening: Who is Willing to be Tested?", Paper presented at the IV International Conference on AIDS, Stockholm, June 12-16, 1988.

of view.<sup>207</sup> As with the existing AIDS case-reporting provisions in Canada, there is reason to doubt whether reporting provisions relating to positive HIV antibody test results would be able to withstand a constitutional challenge.

## B. MEASURES TO REDUCE TRANSMISSION OF HIV

# 1) Counselling of Infected Persons

One of the stated objectives of communicable disease reporting has always been to enable public health officials to ensure that all persons infected with a particular disease receive appropriate counselling about the disease itself and about what measures should be taken in order to avoid transmitting the disease to others. Upon receiving a report of a case of a communicable disease, public health officials would traditionally contact the infected person and apprise him or her of relevant information about the

<sup>&</sup>lt;sup>207</sup> In this regard, it is interesting to note the recent decision of the New South Wales Government to remove HIV infection from the list of proclaimed diseases under the <u>Public Health (Proclaimed Diseases) Amendment Act, (supra,</u> note 151) thereby reversing the previous decision to make positive HIV antibody test results reportable in that state. (Personal communication from Dr. Bruce Whyte, National Health and Medical Research Council Special Unit in AIDS Epidemiology and Clinical Research. Sydney, Australia.)

disease.<sup>208</sup> In the case of HIV/AIDS, the need for both pre and post-test counselling is particularly great because of the potentially adverse psychological consequences of learning that one is infected with the virus<sup>209</sup> and because prevention of infection is the only means available at present for bringing the disease under control.

However, while the need for counselling may be clear, it is not clear that compulsory HIV/ALUS case-reporting is necessary in order to fulfil this need, as there are a number of other ways in which infected persons can be given access to counselling. Where the test is arranged through a physician, the physician can counsel his or her patient about the implications of a positive test result both before and after the test is carried out. The benefits of this approach are that knowledge of the positive test result is restricted to only two people (the physician and the infected person) and that the counselling takes place within the context of the existing relationship between the physician and the patient. Alternatively, where testing takes place at a clinic, all persons returning to the clinic for their test results can be given appropriate counselling.

<sup>&</sup>lt;sup>208</sup> T.Vernon, "The HIV Epidemic: Colorado's Traditional Approach to Disease Control", (1987) 2 <u>AIDS & Public Policy</u> <u>Journal</u> 33, at 33.

Somerville & Gilmore, <u>supra</u>, note 192, at 29.

This counselling can be given on a completely anonymous basis if preferred.

The only justification for compulsory case-reporting in this context, therefore, is where there is a concern that some infected persons are missing out on counselling from other sources or where there is some additional benefit in having the counselling carried out by public health officials rather than by the person's physician or at a clinic. The first point relates to the testing procedure in place within each state or jurisdiction. With appropriate planning, it is possible to ensure that all infected persons receive counselling at the time they receive their test result and that those who fail to return are located and counselled. This can be done without the need for any form of state intervention and can be anonymous, as long as there is an effective way of locating persons who test positive.<sup>210</sup>

The question of whether the counselling procedure is more effective if carried out by public health officials is a highly controversial one. As mentioned above, there is a strong argument that counselling is best carried out within

<sup>&</sup>lt;sup>210</sup> There is evidence that even where a pseudonym is used, at least 75% of persons who test positive can be located and informed of the test result. N.E.Spencer et al., "Follow-Up to Ensure Counseling of HIV-Ab Positive Volunteers to HIV Test Sites", Paper presented at the III International Conference on AIDS, Washington D.C., June 1-5, 1987.

the context of an established physician/patient relationship, if such exists. If physicians are reluctant to undertake this task, or if there is a concern that the counselling by the physician may be inadequate or inappropriate, there may be a justification for public health officials to intervene. However, this must be weighed against the harms of this intervention, which include the threat to confidentiality if more people know of a person's infected status<sup>211</sup>, the harm that might be caused by the intrusion of a third party into a highly sensitive and private problem, and the fear that public health measures such as this may discourage voluntary testing.<sup>212</sup>

Thus, even where there is evidence that counselling by public health officials may achieve some valid purpose, this form of intervention cannot be undertaken lightly, and in some cases, may be unable to be justified because the public health benefit fails to override the other interests adversely affected and could equally be achieved by other, less intrusive, means. It is highly doubtful whether this objective alone would be sufficient to justify the

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<sup>&</sup>lt;sup>211</sup> It should be noted in this regard, however, that even where counselling is carried out by public health officials, it is still possible for a pseudonym to be used. An example of this is the procedure in place in Colorado. See Vernon, <u>supra</u>, note 208, at 34.

<sup>&</sup>lt;sup>212</sup> <u>Supra</u>, at 102-103.

implementation of a compulsory HIV/AIDS case-reporting system.

## 2) <u>Contact-Tracing</u>

The purpose of contact-tracing is to trace the chain of transmission of a particular disease with a view to breaking the chain.<sup>213</sup> The contacts of an infected person are identified, located, and counselled about available testing, treatment and control measures. By intervening in this way, it is hoped to prevent these people from becoming infected, or if already infected, from spreading the disease further.

For obvious reasons, contact-tracing has generally only been used with diseases that have limited modes of transmission. With highly contagious diseases that can be spread by casual contact, it is neither feasible nor efficacious to undertake contact-tracing because of the large numbers of people involved and the difficulty, short of imposing widespread quarantine, of preventing those people from spreading the disease further. However, with other forms of disease, most notably sexually-transmitted

<sup>213</sup> Francis & Chin, <u>supra</u>, note 166, at 1361.

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diseases, contact-tracing has been a common feature of public health programmes.<sup>214</sup>

In the context of HIV/AIDS, the potential benefits of certain forms of contact-tracing are evident. Because persons infected with HIV can remain asymptomatic for long periods of time, there is a high likelihood that many infected persons will not be aware of their condition. Especially where the person does not belong to an identified risk group, he or she may be unaware of the risk of exposure to HIV and is unlikely to consider being tested. Contacttracing can perform a valuable function by alerting these people to the fact that they may have been infected with HIV, enabling them to decide whether to not to be tested and encouraging them to alter their behaviour to avoid being infected or to reduce the risk of transmitting the virus to others.

On the other hand, while potentially beneficial, contact-tracing also raises acute problems of invasion of privacy and breach of confidentiality. Except in those cases where contact-tracing can be carried out without disclosing the identity of the index case, it will inevitably widen the circle of people who know about that

Brandt, <u>supra</u>, note 13, at 150-151.

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person's infected status, and there is often no way of preventing the contacts from further disclosing this information.<sup>215</sup> The process of identifying and locating the contacts of an infected person requires an investigation into some of the most intimate aspects of that person's life and the life of the contacts, and therefore constitutes a highly intrusive public health intervention.<sup>216</sup> This is particularly so when the contact-tracing is carried out without the consent of the index case. As with HIV casereporting, there is a real risk that a policy of mandatory contact-tracing may deter some people from seeking voluntary HIV antibody testing<sup>217</sup>, and may weaken the relationship of confidentiality between physician and patient.<sup>218</sup>

Contact-tracing is also an extremely time-consuming and expensive form of public health intervention, particularly where an infected person has had a large number of contacts. For this reason, it has been suggested that, depending on the prevalence rates in particular communities and the practicability of follow-up, it may be more cost-effective

<sup>218</sup> Gostin & Curran, <u>supra</u>, note 216, at 25.

<sup>&</sup>lt;sup>215</sup> Curran et al., <u>supra</u>, note 54, at 31.

<sup>&</sup>lt;sup>216</sup> L.Gostin & W.Curran, "The Limits of Compulsion in Controlling AIDS", (1986) 16 <u>Hastings Center Report</u> 24, at 25-26.

<sup>&</sup>lt;sup>217</sup> Somerville & Gilmore, <u>supra</u>, note 192, at 41; and Curran et al., <u>supra</u>, note 54, at 31.

to direct resources towards a more widespread programme of education about HIV to encourage changes in behaviour on a general level and to promote voluntary testing.<sup>219</sup> For similar reasons, some contact-tracing programmes aim to trace only those contacts who otherwise would belong to lower risk groups, such as the heterosexual partners of bisexual men or intravenous drug users, on the assumption that those people are less likely to be aware of the risk that they may have been exposed to HIV.<sup>220</sup>

Despite the potential harms and drawbacks of contacttracing, however, there are circumstances in which there clearly exists, at the very least, an ethical requirement to ensure that known contacts of an infected person are advised of the possibility of either past or future exposure to HIV. Failure to do so may result directly in those persons becoming infected or infecting others, and could attract legal liability according to the "duty to warn" principle laid down by a Californian court in the decision of <u>Tarasoff</u>

<sup>&</sup>lt;sup>219</sup> Canadian National Advisory Committee on AIDS, "Human Immunodeficiency Virus (HIV) Infection Contact Tracing Reco.mendations", (1987) 13 <u>Canada Diseases Weekly Report</u> 13, at 13.

<sup>&</sup>lt;sup>220</sup> This was formerly the policy in Ontario. See the Provincial Advisory Committee on AIDS <u>Statement on Contact</u> <u>Tracing of Individuals with HTLV-III/LAV Infection</u>, 18 April, 1986.

v. <u>Regents of the University of California</u>.<sup>221</sup> In Canada, the Canadian Medical Association has endorsed the view that physicians have an ethical duty to carry out contacttracing, if necessary against the wishes of the infected person if there is reason to believe that the patient's current sexual partner is at risk.<sup>222</sup>

The critical question, therefore, is not so much whether contact-tracing should be carried out but when and how it should be done. More specifically, should contacttracing be a voluntary process carried out by infected persons themselves or with their consent and cooperation, or should it be a mandatory requirement imposed by law? If mandatory, should the responsibility for ensuring that contact-tracing takes place rest with physicians or should public health authorities be given powers to monitor contact-tracing requirements? The answer to this question will, in turn, inform an analysis of whether compulsory case-reporting is necessary to achieve the public health objectives of contact-tracing.

<sup>&</sup>lt;sup>221</sup> 131 Cal.Rptr. 14, 551 P.2d 340 (1976).

<sup>&</sup>lt;sup>222</sup> Canadian Medical Association, "Acquired Immunodeficiency Syndrome", (1989) 140 <u>Canadian Medical</u> <u>Association Journal</u> 64A.

### i) Models of Contact-Tracing

There are a number of different models of contacttracing. At one extreme is the least intrusive model whereby persons infected with HIV are encouraged to notify their sexual or needle-sharing contacts themselves.<sup>223</sup> If desired, assistance can be sought from the physician or from public health doctors<sup>224</sup>, but the process is an entirely voluntary one and questions of breaches of confidentiality, at least insofar as the index case is concerned, do not arise. If the person refuses to cooperate, no sanctions are available either to compel him or her to identify contacts or to punish for refusal to do so.

The next level of contact-tracing would impose a positive obligation on physicians to ensure that contacttracing takes place. Physicians would either have to

<sup>&</sup>lt;sup>223</sup> This form of contact-tracing has been recommended by the Centers for Disease Control in the United States (see Gostin & Curran, <u>supra</u>, note 216, at 24) and by the Canadian National Advisory Committee on AIDS (see <u>supra</u>, note 219, at 14).

An example of this is a programme implemented in British Columbia whereby a form was attached to all positive HIV laboratory test results inviting infected persons to anonymously submit contact information to public health authorities for tracing. M.L.Rekart, "A Modified System of Contact Tracing for HIV Seropositives - A Year's Results", Paper presented at the IV International Conference on AIDS, Stockholm, 12-16 June, 1988.

satisfy themselves that the patient had carried out adequate contact-tracing or else would have to undertake the contacttracing themselves or request public health authorities to do so.<sup>225</sup> In the absence of a statutory provision authorising physicians to undertake contact-tracing, there is a question as to whether they could have a legal liability in these circumstances if they disclose information about a person's infected status without that person's consent.<sup>226</sup> At the very least, they could be found guilty of professional misconduct.<sup>227</sup> In New York, where a system of contact-tracing by physicians has been implemented, physicians have an express statutory immunity from liability for disclosing information in the course of contact-tracing.<sup>228</sup>

<sup>227</sup> In Ontario, for example, the definition of "professional misconduct" by physicians under the <u>Health</u> <u>Disciplines Act</u> R.S.O. 1980, c.196 includes: "giving information concerning a patient's condition ... to any person other than the patient without the consent of the patient unless required to do so by law". (R.R.O. 1980, Reg. 448, s.27(22))

An Act to Amend the Public Health Law, the Insurance Law and the Social Services Law in relation to testing for HIV and to the Confidentiality of Information and Records related to HIV Infection and AIDS, S.9265-A, A. 9765-A, July 15, 1988,

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<sup>&</sup>lt;sup>225</sup> Physicians in the Northwest Territories, for example, are subject to such a duty. <u>Communicable Disease</u> <u>Regulations</u>, <u>supra</u>, note 67, s.5.

Possible heads of liability in this context would include defamation, negligent infliction of emotional distress and breach of contract (see Rodgers-Magnet, <u>supra</u>, note 121). It should be noted also that in the case of criminal liability, the defence of necessity may be available (see <u>supra</u>, at 70-72.

A variation of this model of contact-tracing is a procedure whereby physicians have the primary responsibility for undertaking contact-tracing but public health authorities have a supervisory role and the power to intervene in the contact-tracing process if they consider it necessary. Such a system is in force, for example, in Prince Edward Island and Ontario.<sup>229</sup> At this level of contact-tracing, it can be argued that some form of casereporting is required to enable public health officials to follow up reports of AIDS or HIV seropositivity, thereby ensuring that effective contact-tracing has been carried However, as will be discussed later, case-reporting out. for this purpose need not necessarily be in a form that enables each infected person to be identified as long as public health authorities have a means of obtaining information for contact-tracing in those cases where it is required.<sup>230</sup>

# s.2783(3).

<sup>229</sup> Personal communications from Mr Charles Campbell, Deputy Minister of Health, Prince Edward Island, February 24, 1989, and Dr. Evelyn Wallace, Senior Medical Consultant/AIDS Coordinator, Ontario Ministry of Health, February 24, 1989.

<sup>&</sup>lt;sup>230</sup> This is most commonly done by imposing a statutory duty upon physicians to provide such information as is considered necessary by the relevant medical health officer. See <u>infra</u>, at 119-120.

The most intrusive model of contact-tracing is that which places the responsibility for contact-tracing solely in the hands of public health officials. This model has been implemented in Colorado, where "field investigators" are trained to interview all persons reported as HIV seropositive and then to notify any contacts of those persons, offering them access to voluntary testing and counselling as to how to avoid further exposure to or transmission of the virus.<sup>231</sup> One advantage of this system is that all contact-tracing is carried out by persons with a special training and experience in the area, but it inevitably requires the involvement of third parties in the contact-tracing process. It also depends for its operation on the existence of comprehensive HIV/AIDS case-reporting to enable public health authorities to locate all seropositive persons.<sup>232</sup>

## ii) Contact-Tracing Provisions in Canada

Given the widespread acceptance of contact-tracing as an effective public health measure, it is perhaps surprising that there are very few provisions in Canadian public health

<sup>&</sup>lt;sup>231</sup> Vernon, <u>supra</u>, note 208, at 35.

<sup>&</sup>lt;sup>232</sup> This case-reporting would not necessarily have to be nominal, but the need for locating information would mean that confidentiality could never be assured.

legislation which expressly authorise or compel contacttracing. Only three provinces - Manitoba, Prince Edward Island and Alberta - and the Nortnwest Territories and the Yukon have provisions in public health legislation applicable to HIV/AIDS which refer specifically to contacttracing.

In Manitoba, the <u>Regulations Respecting Diseases and</u> <u>Dead Bodies</u><sup>233</sup> impose a duty on any person suffering from a notifiable disease (which includes AIDS but not HIV seropositivity) to advise the local medical officer of the source or suspected source of the infection.<sup>234</sup> It is interesting that this duty imposed upon infected persons seems to facilitate only "retrospective" contact-tracing, that is, tracing the source of the person's infection but not those contacts who may, in turn, have been infected by that person. In contrast, physicians in Manitoba have a duty to report any known contacts of a person infected with a sexually transmitted disease (which again includes AIDS) to the Director of Communicable Disease Control.<sup>235</sup> The Director then has the power to order the contact to undergo

233	<u>Supra</u> ,	note 67.
234	<u>Ibid</u> .,	s.11(2)(a)
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<sup>35</sup> <u>Ibid</u>., s.40(1)(b).

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a medical examination.<sup>236</sup> There is, however, no positive duty on either physicians or public health authorities to carry out contact-tracing, nor any duty to report contacts of HIV seropositive persons.

In Prince Edward Island, every person infected or suspected of being infected with a notifiable disease (which includes AIDS and "HIV antibodies") must identify any contact and provide "such other relevant information as may be required" to the Chief Health Officer.237 The Chief Health Officer can require any suspected contact to adhere to "specific treatment procedures and control measures".<sup>238</sup> As in Manitoba, there is no positive duty to undertake contact-tracing. The Alberta Communicable Diseases <u>Regulation</u>, however, imposes a duty on medical officers of health to "attempt to identify sexual contacts" of persons with AIDS and other communicable diseases.<sup>239</sup> In addition, they are required to take whatever steps are "reasonably possible" to "protect those who have not already been exposed", to "break the chain of transmission and prevent spread of the disease", and to "remove the source of

- <sup>238</sup> <u>Ibid</u>., s.2(h).
- <sup>239</sup> <u>Supra</u>, note 67, Schedule 4.

<sup>&</sup>lt;sup>236</sup> Ibid., s.45.

<sup>&</sup>lt;sup>237</sup> <u>Notifiable and Communicable Diseases Regulations</u>, <u>supra</u>, note 67, s.4(c).

infection".<sup>240</sup> This provision could be construed as requiring contact-tracing to be carried out in some circumstances.

Only the Northwest Territories and the Yukon have provisions which expressly mandate contact-tracing. In the Northwest Territories, physicians are under a duty to "carry out contact-tracing of surveillance or those aspects of the occurrence and spread of the communicable disease that are pertinent to the effective control of the disease", or to "requect the Chief Medical Officer to carry out the contact tracing or surveillance".<sup>241</sup> This must be done within seven days of giving notification of a case of a communicable disease. Physicians in the Yukon must advise any known contacts of a person with a communicable disease "to adopt the specific control measures for such disease" and must "give them the necessary instructions therefor".<sup>242</sup>

Although the remaining provinces have no provisions in their public health legislation which refer specifically to contact-tracing, there are provisions which can be used to

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<sup>&</sup>lt;sup>240</sup> <u>Ibid</u>., s.8(2).

<sup>&</sup>lt;sup>241</sup> Northwest Territories <u>Communicable Diseases</u> <u>Regulations</u>, <u>supra</u>, note 67, s.5(1)(e).

Yukon <u>Communicable Diseases Regulations</u>, <u>supra</u>, note 67, s.5(1).

facilitate contact-tracing by public health authorities. In Ontario, for example, a physician reporting a case of a communicable disease can be required to provide "such additional information respecting the ... disease ... as the medical officer of health considers necessary".<sup>243</sup> Upon receiving a report of a case of AIDS or HIV seropositivity, public health officials in Ontario contact the doctor who submitted the report to ascertain whether contact-tracing has been carried out. If the physician has not notified the contacts, public health authorities invoke the above provision to obtain sufficient information from the physician to enable them to undertake the contact-tracing themselves.<sup>244</sup>

Thus, although contact-tracing is not legally required in most Canadian jurisdictions, public health authorities have recourse to a number of statutory powers to implement contact-tracing as a matter of policy, if so desired. In practice, most Canadian provinces have implemented some form of contact-tracing for HIV/AIDS, although it is rarely the case that public health authorities will proceed with

<sup>&</sup>lt;sup>243</sup> O.Reg. 490/85, s.1(2).

<sup>&</sup>lt;sup>244</sup> Personal communication from Dr. Evelyn Wallace, Senior Medical Consultant/AIDS Coordinator, Ontario Ministry of Health, February 24, 1989.

contact-tracing against the express wishes of the infected person.<sup>245</sup>

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## iii) <u>Contact-Tracing and Compulsory Case-Reporting</u>

When considering whether compulsory HIV/AIDS casereporting is necessary or justifiable in order to facilitate contact-tracing, the first point that emerges from the preceding discussion is that there are ways in which contact-tracing can take place without any form of state intervention or involvement at all. This is the case where contact-tracing is carried out voluntarily by the infected person or by physicians with the consent of their patients. It can be argued that as this form of contact-tracing depends on the cooperation of the infected person, there may be circumstances where the contact-tracing is not completely exhaustive, or in some cases, does not occur at all. On the other hand, however, complete and effective contact-tracing will always depend to some extent on the cooperation of the infected person, and cooperation may be better, overall, in a voluntary system.

<sup>&</sup>lt;sup>245</sup> McGill Centre for Medicine, Ethics and Law, <u>Responding to HIV/AIDS in Canada</u>, 1989 (forthcoming publication).

There are a number of arguments in favour of some degree of state involvement in the contact-tracing process. Some physicians may be reluctant to carry out contacttracing because of concerns about confidentiality or may be unable to do so due to lack of resources. Contact-tracing by a reluctant physician may well be less effective than that undertaken by public health authorities, and these authorities may be able to carry out more extensive contacttracing because of the greater scope of their operations. Moreover, they are in a position to ensure that any contacttracing policy is applied thoroughly and consistently.

If one accepts, however, that some degree of systematic state involvement in the contact-tracing process may be beneficial, even if only at a supervisory level, one is drawn to the conclusion that some form of disease notification is necessary in order to enable public health officials to carry out this function effectively. Unless they are advised of occurrences of the disease, there is no practical way in which they can ensure that appropriate contact-tracing has been undertaken.

However, depending upon the model of contact-tracing that is implemented, the disease notification can take very different forms. If public health officials wish only to ensure that physicians are carrying out adequate contact-

tracing, for example, it may be sufficient for physicians to submit a report using a code number to identify the patient and stating the name of the disease and whether or not contact-tracing has been undertaken. Public health authorities can then contact the physician to obtain further information if required, which is a very different proposition from having a central register containing personal information about each infected person. Only if contact-tracing is to be carried out exclusively by public health officials (or supervised by them on a case-by-case basis) is it necessary to have a comprehensive casereporting system with personal identifiers attached to each report.

What then is the relationship between the need for contact-tracing in relation to HIV/AIDS and compulsory HIV/AIDS case-reporting? Clearly, an argument can be made that some form of case-reporting is necessary in order to facilitate models of contact-tracing that require state supervision or participation. If one accepts that this contact-tracing is a significant and desirable public health objective, it could provide a justification for compulsory case-reporting. What is important to bear in mind, however, is that only those case-reporting requirements that are necessary specifically to facilitate the contact-tracing can be justified on this basis.

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As with case-reporting for epidemiological purposes, HIV/AIDS case-reporting requirements in Canada go beyond what is necessary for contact-tracing purposes. As discussed above, contact-tracing carried out with the cooperation of the physician and the infected person, even when supervised by public health authorities, does not require case-reporting by name. In some cases, notification could be given without any personal identifying information at all, as long as it is possible for the person to be traced through the physician if necessary.<sup>246</sup> Despite this, most Canadian provinces require HIV/AIDS case reports to include a large amount of personal information.<sup>247</sup>

Similarly, reporting requirements imposed upon persons without medical qualifications and which compel the reporting of a mere suspicion or belief that someone is infected with HIV are of doubtful value for contact-tracing purposes, because of the unreliability of the information so obtained. Further, a report of one unconfirmed positive

Even in Colorado, where the public health department pursues an active policy of contact-tracing, there is provision for a person to take the HIV antibody test under a pseudonym and to be located subsequently by means other than name. See Vernon, <u>supra</u>, note 208, at 34.

<sup>&</sup>lt;sup>247</sup> <u>Supra</u>, at 53-58.

ELISA test result (such as is required in Nova Scotia<sup>248</sup>) should not be the basis for an action that intrudes upon a person's private life to the degree that is necessitated by contact-tracing.

Thus, while contact-tracing may be a legitimate objective of compulsory case-reporting, it cannot be used without question to justify the form of HIV/AIDS casereporting requirements that exist today in many Canadian jurisdictions. In view of the potential harms of compulsory case-reporting, especially the risk of discouraging voluntary testing<sup>249</sup>, compounded by the potential additional harms of contact-tracing<sup>250</sup>, extreme caution must be exercised when implementing either policy. At the very least, case-reporting requirements should be as narrow as possible while still enabling contact-tracing to be carried out.

One final point that should be made in this regard is that if public health authorities are to perform any effective role in contact-tracing with HIV/AIDS, the system of case-reporting upon which their intervention is based

248	<u>Supra</u> ,	at	43-44.
249	<u>Supra</u> ,	at	102-103.
250	Supra,	at	109-110.

must rationally encompass cases of HIV seropositivity as well as cases of AIDS. Contacts of HIV seropositive persons are just as much at risk as contacts of persons with AIDS, and in fact may be less likely to be aware of the risk because their partner displays no clinical signs of disease. This, therefore, is perhaps the most compelling argument for having some form of reporting requirement for positive HIV antibody test results.

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### V. CONCLUSIONS

Compulsory case-reporting of communicable diseases has been such a common feature of public health programmes in the past, that the rationale and justifications underlying it have, to a large extent, ceased to be subject to close scrutiny. In the case of diseases that do not carry the stigma associated with HIV/AIDS, this is perhaps understandable. We accept that that the protection of public health is a desirable goal, and in the absence of compelling arguments to the contrary, are prepared to accept those public health measures that seem to contribute towards the attainment of that goal.

AIDS, however, has provided us with compelling arguments against such an uncritical approach to compulsory case-reporting. While the protection of public health has, if possible, assumed an even greater importance - and certainly a greater sense of urgency - the AIDS epidemic has at the same time brought the realisation that the processes involved in protecting public health are complex and require a careful balancing of different interests and values. As part of this process, compulsory HIV/AIDS casereporting requirements must be put to the test to see if

the values they express are ones that we are prepared to acknowledge and endorse.

There is little evidence that the reporting provisions in Canada and elsewhere have been subjected to any such examination. The various reporting requirements are so diverse, and in some cases, so obviously inappropriate in the context of HIV/AIDS, that it is difficult to detect any common purpose or principle underlying them. Although the stated objectives of disease reporting have been wellestablished, many of the existing provisions, when applied to HIV/AIDS, seem to bear little relationship to those objectives. Moreover, even the objectives themselves can now be seen as controversial in light of the potential harmful consequences of many forms of public health intervention that are based on compulsory reporting.

This is not to suggest that compulsory case-reporting should necessarily be abandoned as a public health measure against HIV/AIDS. There are strong arguments in favour of AIDS case-reporting for epidemiological purposes, and reporting of both AIDS and HIV seropositivity may facilitate contact-tracing programmes that could contribute substantially to a reduction of the spread of HIV. However, what is clear from this study is that even these objectives are not always achieved by the existing case-

reporting requirements, and that as a result, the legitimacy of this form of public health intervention must be brought into question.

This issue has a further dimension, namely the harm that can be caused by the use of coercive measures in such circumstances. The question is particularly critical in the case of HIV/AIDS because of the far-reaching social, cultural and political implications of the disease. Public health policy cannot be regarded in isolation; it is part of a web of responses to HIV/AIDS which influence and react to each other. Thus, inappropriate public health measures may be worse than ineffective, as they may trigger a chain of other responses which together combine to obstruct an informed and compassionate approach to the disease. There are signs that some HIV/AIDS case-reporting provisions may indeed be part of such a process because of their impact upon voluntary testing and treatment and because of the way in: which they operate on a symbolic level to signify a certain form of response to the disease. These are vitally important considerations which must inform any reassessment of health policy in this context.

It is to be hoped that this process of reassessment will shed some light upon how the law can contribute in a positive sense towards a better and more effective public

health policy. It has become clear that the traditional, coercive interventions such as quarantine and isolation do not provide all the answers. At the same time, however, there is an emerging sense of how the law can be used in a constructive way both to respond to and to influence the many dimensions of HIV/AIDS. In a dramatic and tragic way, the AIDS epidemic has provided the opportunity for a reevaluation of what can and should be achieved by the use of law in the public health context. It would only compound the tragedy if this opportunity were lost.

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