Legislation to Authorize Forced Testing for HIV In the Event of Occupational Exposure: An Unjustified and Unnecessary Rights Violation

A submission to the Government of Manitoba

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Introduction

The Canadian HIV/AIDS Legal Network ("Legal Network") understands that a bill that would authorize the forced testing of people for HIV and other diseases in some situations of possible occupational and non-occupational exposure will be introduced in the Legislative Assembly of Manitoba in April 2008.

The Legal Network wishes to take this opportunity to comment on the proposed bill. The Legal Network supports measures to prevent the spread of HIV, including for workers such as police officers, firefighters, ambulance attendants, paramedics and those providing emergency assistance (collectively referred to as emergency responders in this submission) and health care workers. The Legal Network also supports access to quality HIV testing and counselling, and access to care, treatment and support for those who may be exposed to the risk of HIV infection, whether occupationally or otherwise. Finally, we support measures that respect and protect the rights of people living with HIV and those vulnerable to HIV infection.

However, legislation that authorizes compulsory blood testing is not a measure to prevent the spread of HIV, nor an example of quality HIV testing, counselling, care, treatment or support for those exposed to the risk of infection. Compulsory blood testing is not a measure that respects and protects the right of people living with or vulnerable to HIV infection. Therefore, this submission sets out our position as to why legislation authorizing the forced testing of people for HIV should not be enacted by Manitoba.

Legislation authorizing the forced testing of people for HIV (i.e., without a person's informed consent) does not represent an appropriately balanced policy response to the issue of occupational and non-occupational exposures to HIV. **Forced testing legislation is a flawed approach that does not adequately respect and protect human rights. Occupational exposure to HIV is an example of a situation where a legal "quick fix" is not the best solution to a complex problem.**

Workers who risk exposure to blood-borne pathogens such as the Hepatitis B and C viruses and HIV deserve a more considered, comprehensive response from legislators, a response that would help ensure the human right to safe and healthy working conditions is fulfilled, thereby offering real protections for such workers.[1] Moreover, ensuring

[1] The right to just and favourable conditions of work, including safe and healthy working conditions, is set out in the *International Covenant on Economic, Social and Cultural Rights*, Article 7(b). Canada has ratified this treaty.

access to adequate information, counselling, support and treatment in the event of an exposure is more beneficial to emergency responders than are the test results sought through this type of legislation. An approach that offers real HIV prevention and support, and protects the human rights of everyone involved represents a more constructive and useful alternative.

We note by way of background context for the submissions that follow, that Manitoba currently has a comprehensive protocol and guidelines to manage occupational and other exposures to blood and body fluids.[2] Notably, these guidelines state that all testing is to be voluntary and informed consent must be obtained prior to all testing, both for the exposed person and the source person.

About the Canadian HIV/AIDS Legal Network

The Canadian HIV/AIDS Legal Network (www.aidslaw.ca) is a national organization engaged in research, education and policy development on legal issues related to HIV/AIDS. The Legal Network promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally. We have over 100 members across Canada and around the world, many of whom are community-based organizations and AIDS service organizations.

The Legal Network has been involved in extensive government, community and international consultations regarding a diverse range of human rights and policy issue related to HIV/AIDS. HIV testing and disclosure issues have been a key aspect of the Legal Network's research and analysis for many years. This includes extensive work specifically on the issue of compulsory HIV testing. In 2001 we produced *Testing of Persons Believed to Be the Source of an Occupational Exposure to HBV, HCV, or HIV: A Backgrounder*.[3] In 2002, based on the *Backgrounder*, we produced *Occupational Exposure to HIV and Forced HIV Testing: Questions and Answers*.[4] In February 2002, the Legal Network appeared before the House of Commons Standing Committee on Justice and

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[2] *Integrated Post-Exposure Protocol: Guidelines for Managing Exposures to Blood/Body Fluids*. Manitoba. November 2003. Available at www.gov.mb.ca/health/publichealth/cdc/fs/ipep.pdf.

[3] T de Bruyn. *Testing of Persons Believed to Be the Source of an Occupational Exposure to HBV, HCV or HIV: A Backgrounder.* Canadian HIV/AIDS Legal Network. 2001. Unless otherwise indicated, data and studies referenced in this brief are drawn from that document. Please refer to the *Backgrounder* for citations to the original sources. The *Backgrounder* is available on-line via www.aidslaw.ca/testing. Please note that French versions of Legal Network documents regarding HIV testing are available via www.aidslaw.ca/test.

[4] T de Bruyn. *Occupational Exposure to HIV and forced HIV Testing: Questions and Answers*. Canadian HIV/AIDS Legal Network. 2001. Available via www.aidslaw.ca/testing.

Human Rights on Bill C-217, the proposed "Blood Samples Act." We presented written and oral submissions highlighting the serious human rights issues raised by the legislation. On the Standing Committee's recommendation, the Bill did not proceed. In 2007, we produced a booklet entitled *Undue Force: An Overview of Provincial Legislation on Forced Testing and HIV* examining the existing or pending legislation allowing for forced testing for blood-borne diseases in Ontario, Alberta, Nova Scotia, Saskatchewan and Manitoba.[5]

[5] Available via www.aidslaw.ca/testing.

1. HIV Testing: the "3 Cs"

Both globally and within Canada, human rights-based responses to HIV/AIDS have been broadly endorsed.[6] Practically speaking, this means that human rights principles and protections should be at the heart of all policy decisions related to HIV testing. The "3 Cs" approach has become the accepted rights-based approach to HIV testing, shown to be effective[7] and endorsed by the United Nations.[8] The principles of the "3 Cs" approach are:

- HIV testing may only occur with specific **informed consent** voluntarily given. This requirement derives from the human right to *security of the person*[9] – that is, being able to control what happens to one's body – as well as from the *right to information*[10] that is an integral part of the right to health.
- **Pre- and post-test counselling** of good quality must be provided with every HIV test. This counselling gives effect to the *right to information* and is essential for both promoting the mental health of persons getting tested and protecting public health more broadly by helping to prevent onward transmission of HIV. Good quality counselling is of particular importance for people who may not otherwise get appropriate information on HIV/AIDS.
- **Confidentiality** of HIV test results, and even of the fact that someone has sought to be tested, must be protected. The confidentiality of medical tests derives from the *right to privacy*[11] and is a central element of ethical medical practice.

Compulsory testing is directly antithetical to the spirit of the rights-based approach embodied by the "3 Cs" approach to testing. Informed, voluntary consent is essential. Moreover, the right to be free of discrimination and the right to security of the person, in our view, require that in setting HIV testing policy governments must take into account the

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[6] E.g., see *Leading Together: Canada Takes Action on HIV/AIDS (2005/2010)*. Ottawa: Canadian Public Health Association, 2005; *International Guidelines on HIV/AIDS and Human Rights*, 2006 Consolidated Version. Geneva: UNAIDS & Office of the UN High Commissioner for Human Rights, 2006.

[7] The Voluntary HIV-1 Counseling and Testing Efficacy Study Group, "Efficacy of voluntary HIV-1 counselling and testing in individuals and couples in Kenya, Tanzania and Trinidad: a randomised trial," *Lancet* 2000: 356: 103-12.

[8] UNAIDS/WHO Policy Statement on HIV Testing (Geneva, June 2004).

[9] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11, at s.7; *International Covenant on Civil and Political Rights*, 999 U.N.T.S. 171, Article 9 [ICCPR].

[10] ICCPR, Article 19.

[11] *Canadian Charter of Rights and Freedoms*, ss. 7 and 8; ICCPR, Article 17.

outcomes of HIV testing for people — including stigma, discrimination, violence and other abuse — and take steps to prevent human rights violations associated with this health service.

Under Canadian and international law, any public health action by the state that limits human rights must be justified by demonstrating that it is rationally connected to achieving a pressing objective, infringes rights as little as possible, and that the benefit must be proportional to the harm done to individuals' human rights.[12] It is our submission that legislation authorizing forced HIV testing would not pass this test, and as shall be demonstrated below, it is unnecessary in order to offer appropriate protections to emergency workers risking exposure to blood-borne pathogens in the course of their duties. **Forced blood testing legislation as proposed in Manitoba therefore represents an unjustified and unnecessary violation to human rights and should not be adopted.**

2. Risks and management of occupational exposures

It has become apparent over the years — including in testimony before the House of Commons Standing Committee that ultimately recommended against proceeding with forced testing legislation at the federal level — that **there remains a great deal of misinformation about HIV, the risks of transmission through occupational exposures, and what should be done in the event of such exposures.** Too often, such misinformation fuels calls for ill-conceived responses such as legislation authorizing forced testing for HIV and other blood-borne pathogens such as the Hepatitis B and C viruses.

A proper understanding of the basic facts is vital when considering whether such proposals are warranted or justified. **Legislation should be informed both by a commitment to respecting and protecting human rights and by the best available medical and scientific evidence.** To that end, in this section we provide an overview of the transmission risks and post-exposure treatments for the three blood-borne pathogens of primary concern – HIV, the Hepatitis B virus (HBV) and the Hepatitis C virus (HCV).

Significant exposure to HBV, HVC or HIV occurs when a body fluid capable of transmitting the virus comes into contact with:

- tissue under the skin (e.g., through a needle stick or cut), which is called a percutaneous exposure;

[12] *R.* v. *Oakes*, [1986] 1 SCR 103; *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, UN Doc. E/CN.4/1985/4, Annex (1985).

- mucous membranes (e.g., through a splash to the eyes, nose or mouth), which is called a mucocutaneous exposures; and
- non-intact skin (e.g., skin that is chapped, scraped or afflicted with dermatitis).

Contact with skin or clothing is not a significant exposure.

The types of body fluids capable of transmitting HBV, HVC and HIV include:

- blood, serum, plasma, and all biological fluids visibly contaminated with blood;
- laboratory specimens, samples or cultures that contain concentrated HBV, HVC or HIV;
- organ and tissue transplants;
- breast milk;
- pleural, amniotic, pericardial, synovial and cerebrospinal fluid;
- uterine/vaginal secretions and semen; and
- saliva (saliva on its own may transmit only HBV; if saliva is contaminated by blood, it may also transmit HCV and HIV).

HBV, HCV and HIV are *not* transmitted by feces, nasal secretions, sputum, tears, urine or vomit, unless they are visibly contaminated by blood.

The factors that influence the risk of infection from a single exposure include:

- the virus involved;
- the type of exposure;
- the amount of blood involved in the exposure; and
- the amount of the virus in the source person's blood at the time of exposure (the amount of HIV in the blood is higher in the initial stage of HIV infection and in the final stage of AIDS).

Injuries that are deep, involve a device that is visibly contaminated with the source person's blood, involve a needle that has been placed in the source person's vein or artery, and involve a source person with terminal illness are associated with a higher risk of HIV transmission in health-care workers suffering occupational percutaneous exposure to HIV-infected blood.[13]

[13] DM Cardo et al., A case-control study of HIV seroconversion in health care workers after percutaneous exposure. *New England Journal of Medicine* 1997: 337(21): 1485-1490 at 1487.

2.1 HIV

Risk of transmission

Almost all available data on the risks of occupational transmission of HIV comes from exposures in health-care settings. The US Centers for Disease Control and Prevention (CDC) and the BC Centre for Excellence in HIV/AIDS have estimated that the **risk of infection from a single *percutaneous* exposure to HIV-infected blood is 0.3% (1 in 300).** In other words, there is a 99.7% probability that any such exposures will not lead to infection. This kind of direct, under-the-skin exposure to contaminated blood presents the greatest risk of transmitting HIV, and even then this is very low risk.

The **risk of infection is lower for *mucotaneous* exposures to HIV-infected blood, at about 0.1% (1 in 1000).** If the HIV-positive source person is taking anti-retroviral drugs, the chance of infection is lowered further because the drugs reduce the amount of virus in their blood (even to the point where the virus is clinically undetectable). If the HIV status of the source person is unknown, statistically the chance of infection from any exposure is even lower still.

Given these very low risks, it is not surprising that **there have been only two probable cases, and only one definite case, of occupational transmission of HIV in Canada since the beginning of the epidemic.** The two probable cases involved laboratory workers working with contaminated blood, one in the early 1980s (before HIV was identified) and one working with cultured virus during research activities. The definite case was that of a health-care worker not wearing gloves who sustained a puncture wound involving a patient in the late stage of AIDS (when body fluids have elevated concentrations of HIV) and who did not seek post-exposure treatment with anti-retrovirals. Given the availability of protective devices (e.g., gloves, safety-engineered needles) and the procedures set out in Manitoba's *Integrated Post-Exposure Protocol*, occupation exposures such as these are not common or typical of those that occur today.

There is little data on occupational exposures among emergency responders (e.g., firefighters, ambulance attendants, police and correctional staff). The Chief Medical Officer of Health for Ontario, however, told a committee of that province's legislature that there have been no documented cases of "emergency services workers" (meaning

police officers, firefighters and ambulance attendants) acquiring blood-borne pathogens occupationally in Ontario or in Canada.[14]

Post-exposure treatment

Following an occupational exposure to HIV, if *post-exposure prophylaxis* (sometimes referred to as PEP) is indicated in order to reduce the risk of infection, it will consist of treatment with two or three anti-retroviral drugs for a recommended period of 4 weeks.[15] The degree of risk incurred in the exposure determines whether or not post-exposure prophylaxis is appropriate.

According to Manitoba's *Integrated Post-Exposure Protocol,* PEP is only appropriate where a "significant exposure" has occurred *and* the source person is known to be HIV-positive or the HIV-status of the source person is unknown and other risk factors are present. A "significant exposure" is defined as "an injury during which one person's blood or other high-risk body fluid comes into contact with another person's body cavity; subcutaneous tissue; or non-intact, chapped, or abraded skin or mucous membrane."[16]

For maximum effectiveness, post-exposure prophylaxis should be initiated as soon as possible after exposure, and ideally within 2 to 4 hours according to Manitoba's *Integrated Post-Exposure Protocol*.[17] Animal studies suggest that post-exposure prophylaxis probably is substantially less effective when started more than 24 to 36 hours following the exposure. Available data indicate that post-exposure prophylaxis for humans exposed in non-occupational settings is less likely to be effective if initiated 72 hours or later post-exposure.[18]

There are side effects for roughly three-quarters of those taking post-exposure prophylaxis. The most common are nausea, malaise or fatigue, headache, vomiting and diarrhea. These symptoms can often be

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[14] Dr Colin D'Cunha, Chief Medical Officer of Health for Ontario. Submission to the Standing Committee on Justice and Social Policy, Legislature of Ontario, 4 December 2001.

[15] US Public Health Service (Centers for Disease Control and Prevention). Updated US Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV and HIV and Recommendations for Postexposure Prophylaxis. *MMWR* 2001; 50 (No. RR-11) (29 June 2001) . Available at www.cdc.gov/mmwr/PDF/RR/RR5011.pdf. [Hereinafter "CDC Guidelines"].

[16] *Integrated Post-Exposure Protocol: Guidelines for Managing Exposures to Blood/Body Fluids*, at s 2.

[17] Ibid. at s 11.2.

[18] US Public Health Service (Centers for Disease Control and Prevention). Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States. *MMWR* 2005; 54 (No. RR-2) (21 January 2005). Available at www.cdc.gov/mmwr/PDF/rr/rr5402.pdf

managed with anti-nausea or anti-diarrhoea medications, or by modifying the dose interval (i.e., administer a lower dose more frequently). However, not all side effects can be adequately mitigated and they may result in time off work for individuals taking PEP. Side effects are also a principal reason for not completing the full course of post-exposure prophylaxis. Adverse side effects usually cease when treatment is stopped.

2.2 Hepatitis B

Risks of transmission

A preventive vaccine for HBV is available and those vaccinated are at virtually no risk of infection. All emergency responders and health care workers should be offered this vaccine as a truly effective protection against the occupational hazard of HBV infection, and removing any need for even contemplating forced testing for HBV following a possible exposure. Many members of the general public have also received this vaccine or have developed a natural immunity to HBV as result of exposure.

Post-exposure treatment

If the exposed person has not been vaccinated against HBV, the post-exposure prophylaxis will consist of hepatitis B vaccine and possibly hepatitis B immune globulin (HBIG). HBV vaccination is safe and reports of any serious adverse effects resulting receiving HBIG have been rare.[19] Vaccination helps prevent HBV infection in the exposed person and also protects against infection in the event of future exposures.

2.3 Hepatitis C

Risk of transmission

There is no preventive vaccine for HCV. According to the US CDC's most recent guidelines on managing occupational exposures, however, HCV "is not transmitted efficiently through occupational exposures to blood."[20]

[19] Ibid. at 5.

[20] Ibid. at 6.

The risk of infection from a single percutaneous exposure to HCV-infected blood (i.e., the occupational exposure with the highest degree of risk) is estimated to be 1.8%. The risk of infection following mucotaneous exposure to HCV-infected blood is not known exactly, but is believed to be very small.

Post-exposure treatment

There is no post-exposure prophylaxis for exposure to HCV.

3. The limited benefits that compulsory testing legislation might offer to exposed persons

Forced testing legislation such as that being proposed in Manitoba is supposed to benefit people potentially exposed to HIV, HBV and HVC by providing information regarding the source person's HIV, HBV or HCV status. This information is said to benefit the exposed person because it can be used:

> (1) to inform the exposed person's decisions about post-exposure prophylaxis;
>
> (2) to inform the exposed person's decisions about precautions to prevent secondary transmission to others (e.g., sexual partners, breastfeeding infants); and
>
> (3) to alleviate anxiety about the possibility of infection.

Each of these is an important consideration. Persons who have been exposed to blood or other bodily fluids need accurate information and support in order to access their degree of risk, make appropriate decisions and deal with anxiety.

However, as will be discussed in this section, these purported benefits of forced testing are subject to important qualifications. These qualifications must be taken into account both in assessing the balance of benefits and harms that such legislation carries and in the interests of ensuring exposed persons are given the information they need.

3.1 The rare circumstances in which compulsory testing legislation would offer any potential benefit

First, it must be remembered that the benefits of legislation authorizing compulsory testing only exist in those circumstances where:

- there has been a *significant exposure* to the risk of infection;
- the source person is available to be tested; and
- the source person does not consent to testing.

Most of those who are likely to be occupationally exposed to HBV have likely already received a very effective preventive vaccine. This means there will be few cases in which an occupational exposure to HBV will carry any significant risk of the exposed person being infected. In the case of HCV and HIV, it would only be those cases where one person's blood or other high-risk bodily fluid (i.e., not saliva, sputum, urine, etc.) comes into contact with another person's bodily cavity, subcutaneous tissue, non-intact skin or mucous membrane that could be considered a significant exposure. It is therefore **only a small subset of cases of occupational exposure where there might be a great enough concern about the risk of infection to even consider testing the source person.**

Furthermore, it has been established that **in the overwhelming majority of cases of occupational exposure, the source person consents to testing.**[21] A study of exposures of US police officers, for example, reported that 94% of source persons consented to testing. The House of Commons Committee that examined Bill C-217 heard testimony from an Alberta physician specializing in infectious diseases that approximately 99% of source patients consent to being tested in cases of occupational exposures to health care workers in hospitals.[22] In the first six months of study by the Canadian Needle Stick Surveillance Network, 83% of known source persons agreed to be tested.[23] Finally, it has been reported that in one hospital in British Columbia with over 1,700 significant exposures, all but two source people agreed to be tested; in Ontario, none of 2,600 refused to be tested.[24]

It may well be that in some cases the source person refuses to be tested, but we submit that **evidence of a significant problem should be**

[21] This information was presented by various parties to the House of Commons Standing Committee on Justice and Human Rights with regard to Bill C-217, including by the Member of Parliament who introduced the bill. See: Hon. Chuck Strahl, Member of Parliament. Evidence to the House of Commons Standing Committee on Justice and Human Rights, 12 December 2001.

[22] Dr Steven Shafran, Professor of Medicine, Director of Infectious Diseases Division, University of Alberta Hospital. Evidence to the House of Commons Standing Committee on Justice and Human Rights, 14 June 2000.

[23] S Onno. Oral presentation at the 9th Annual Conference of the Canadian Association of Nurses in AIDS Care, 2001. For discussion, see *Backgrounder*, at 7.

[24] Dr Chris Archibald, Chief, Division of HIV/AIDS Epidemiology and Surveillance, Department of Health. Evidence to the House of Commons Standing Committee on Justice and Human Rights, 27 February 2002. Dr Archibald was testifying before the committee in relation to Bill C-217, the proposed federal "Blood Samples Act."

required before we step onto the slippery slope of passing legislation that authorizes testing people for HIV without their consent. Because the vast majority of source people agree to be tested when a significant exposure happens, **in most cases of occupational exposure, forced testing legislation serves no purpose.**

3.2 Making decisions about post-exposure prophylaxis

The source person's serological test result can provide useful information for making decisions about post-exposure prophylaxis and if available, this information should be taken into account. Other information such as risk factors of the source person, the nature and extent of the exposure, and the source person's treatment history using anti-retroviral drugs should also be taken into account when it is available.

HIV

A person occupationally exposed to HIV must make a decision as to whether to initiate post-exposure prophylaxis. Does testing a source person for HIV offer such a benefit to the exposed person's decision-making process (in the handful of cases where there has been a significant exposure and the source person does not consent to testing) that it justifies overriding the rights of the source person, with the attendant harms?

Current medical advice is that post-exposure prophylaxis for HIV should be initiated within a matter of hours after the exposure. It is unlikely that in such a short period of time it will be possible to comply with the procedural safeguards set out in the legislation (such as arranging a judicial hearing to obtain a warrant, a safeguard which is required to justify the infringement of a constitutionally-protected right in the circumstances),[25] provide appropriate pre- and post-test counselling to both the exposed person and the source person, draw a blood sample from the source person, and then deliver the test results.

Even if these test results can be obtained within a matter of a few hours through an extremely expedited process and the use of "rapid tests" on-site, testing the source person provides only some of the information needed to determine whether the exposed person is at risk of infection and should initiate post-exposure prophylaxis.

[25] See e.g., *R v Dyment*, [1988] 2 SCR 417 at 438.

With respect to rapid tests, it should also be noted that these are *screening* tests only – they *do not* provide the confirmed test results currently available using laboratory procedures that consist of repeated testing using different kinds of tests. Due to the possibility of both false negative and false positive results, it is recommended that all reactive rapid tests are followed-up by laboratory-based confirmatory testing.[26]

What is being proposed with this legislation is to authorize compulsory HIV testing when, in the short period of time during which it might be of any possible benefit, the information that would be available is only an unconfirmed screening test result. The exposed person is still confronted with decisions about post-exposure prophylaxis and anxiety about possible infection, without definitive information on which to rely.

Some people choose to discontinue post-exposure prophylaxis if the source person tests HIV-negative. While an HIV-negative test result provides some reassurance, it does not rule out the possibility that the source person (and by extension the exposed person) might still be HIV-infected. The source person might be within the "window period," having been infected but not yet registering as such on the test.[27] Advances in HIV testing technology have reduced the "window period" significantly, but it remains a reality.

The "window period" is particularly relevant if the source person has recently engaged in high-risk activities, such as sharing drug-injection equipment or having unprotected sex. If high-risk activities were known or suspected by the exposed emergency responder or health care worker — as might well be in some circumstances, such as the police officer stuck with a needle in the course of searching someone incident to their arrest — he or she would no doubt be concerned about possible infection. In these circumstances, concern about the possibility of a "false negative" test would be greatest and reliance on a rapid test result would seem most precarious.

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[26]Public Health Agency of Canada. "Point-of-Care HIV Testing Using Rapid HIV Test Kits: Guidance for Health Care Professionals," *Canada Communicable Disease Report*, 2007: 33S2, 1-22, at p. 6.

[27] For a description of different testing technologies available for HIV, HCV and HBV see N. Constantine, et al. HIV Antibody Assays, *HIV insite*, May 2006. Available at: http://hivinsite.ucsf.edu/Insite?page=kb-00&doc=kb-02-02-01. See also S Stramer et al. Detection of HIV-1 and HCV infections among anti-body negative blood donors by nucleic acid-amplification testing. *New England Journal of Medicine* 2004; 351(8): 760-768; J Barletta. Lowering the detection limits of HIV-1 viral load using real-time immuno-PCR for HIV-1 p24 antigen. *American Journal of Clinical Pathology* 2004; 122(1): 20-27; F Hecht et al. Use of laboratory tests and clinical symptoms for the identification of primary HIV infection. *AIDS* 2002; 16(8):1119-1129.

HBV

Given the availability of a highly effective preventive vaccine, and post-exposure prophylaxis that carries no appreciable risk of harm, knowing the person's HBV status is not necessary for treatment decisions. Decisions regarding post-exposure prophylaxis, therefore, are not a compelling rationale for compulsory testing of the source person for HBV.

HCV

There is no preventive vaccine against HCV nor is there a known effective post-exposure prophylaxis. In the absence of such medical options, decisions regarding post-exposure prophylaxis cannot be a relevant consideration regarding testing the source person for HCV.

3.3 Preventing secondary transmission

HIV

Persons exposed to HIV should be counselled about safer sex practices and about advising their sexual partners of the potential risk of transmission, as well as counselled about avoiding other activities (e.g., sharing needles) that pose a risk of transmission. Women should avoid becoming pregnant until reasonably sure they are not infected (based on a negative HIV test result at 3 months or 6 months at the outside), and if already pregnant, should be advised of the use of anti-retroviral therapy and other interventions to effectively eliminate the chance of transmitting the virus to their child during gestation or labour/delivery. If relevant, women should also be counselled about the risks of breast-feeding and advised about feeding alternatives. **All of these are temporary behaviour modifications and can be undertaken whether or not the source person's HIV status is known. Preventing secondary transmission, therefore, is not a compelling reason to allow forced testing of source persons.**

HBV and HCV

A person exposed to blood infected with HCV or HBV need not take any special precautions to prevent secondary transmission during the follow-up period (such as modifying sexual practices or refraining from becoming pregnant). They should refrain from donating blood, plasma, organs, tissue or semen.[28] Knowing the source person's HCV or HBV status is not

[28] CDC Guidelines, at 23.

necessary for this. Preventing secondary transmission is, therefore, not a compelling rationale for compulsory testing of the source person for HCV or HBV.

3.4 Alleviating anxiety of the exposed person

A person who has experienced a significant occupational exposure to blood (and potentially blood-borne pathogens) will no doubt experience anxiety. This anxiety is likely to persist until he or she is outside the window period and has tested negative for HBV, HCV or HIV.[29]

The majority of people who become infected with HIV seroconvert within the first 3 months following exposure, and often within the first few weeks. Ninety-five percent will have seroconverted (that is, test HIV-antibody positive) within 6 months following exposure. Therefore, if the exposed person has not seroconverted by 3 months, or certainly by 6 months, following the exposure, the chances of seroconverting beyond that point are practically nil.

There is no question that receiving a source person's *negative* test results for any of HBV, HCV or HIV can relieve some of the anxiety of the exposed person (and their loved ones) about possible infection, as it means it is statistically less likely that they have been infected as a result of the exposure.[30] (Of course, as already noted, it is possible that the negative result is a false negative if the source person is in the window period before HIV is detectable by standard tests or if a rapid test produces a false negative result.)

Knowledge of the source person's HIV test result may be a double-edged sword with respect to the anxiety felt by the exposed person as they wait for their own test results following an exposure. **In cases where the source person tests *positive* for HIV, this information will only *increase* the exposed person's anxiety during the waiting period although they remain at a low chance of being infected** (see above). The point is simply that, as with the other benefits said to flow from

[29] Specific antibody to HIV is produced shortly after infection; the exact time depends on several factors including host and viral characteristics. Using early-generation HIV tests, HIV antibodies can be detected within 6 to 12 weeks after infection (the time period prior to tests being able to detect the antibodies is what is referred to as the "window period"). Some newer tests however are able to detect antibodies at about 3-4 weeks after infection. See N. Constantine, HIV Antibody Assays, note 27 above.

[30] In the case of the exposed person already vaccinated against HBV, providing adequate information to the exposed person about the effectiveness of the preventive vaccine should go some considerable distance toward alleviating concern following exposure, meaning the anxiety-alleviating value of knowing the source person's HBV test result is much less significant.

knowing the source person's status, the claimed benefit of alleviating anxiety is a qualified one.

Ensuring that appropriate counselling and information is provided to the exposed person is as important as testing in achieving the goal of relieving the exposed person's anxiety. Counselling can and should be done without resort to compulsory testing. Many exposed police officers, fire fighters, health care workers and good Samaritans believe that they are at much higher risk of infection than the circumstances of their exposure indicate, or do not fully understand window periods and what the test results mean. This misinformation is a tremendous source of anxiety to exposed persons and it is fully avoidable. **Access to accurate, quality information would indeed go a long way to relieve anxiety amongst those who have been potentially exposed to infection.** That no emergency responders and exceedingly few health care workers (1 definite, 2 probable) have actually been infected with HIV in Canada through occupational exposure is the type of critical information that truly would relieve anxiety.

4. Compulsory testing legislation violates human rights

The qualified benefits offered by compulsory testing must be weighed against legal and ethical concerns based on values Canadian society considers important. In this regard, the Legal Network raises three concerns regarding the proposed compulsory testing legislation:

- the disregard for the ethical and legal principle of informed consent;
- unjustified infringements of Charter rights; and
- the inconsistency, from a public policy perspective, of imposing compulsory testing on source persons of emergency responders, and not *vice versa*.

4.1 The legal and ethical doctrine of informed consent

Forced testing violates the legal and ethical principle of informed consent.

The legal doctrine of informed consent reflects the fundamental principle of respect for persons and their autonomy. **The Supreme Court of Canada has repeatedly recognized that a person cannot be subjected to medical procedures without his or her informed consent**.[31] This

[31] *Reibl v Hughes*, [1980] 2 SCR 990; see also: *Hopp v Lepp*, [1980] 2 SCR 192; *Ciarlello v Schacter*, [1993] 2 SCR 119; *Malette v Shulman* (1990), 37 OAC 281 (CA); *Fleming v Reid* (1991), 82 DLR (4th) 298 (Ont CA); *Videto v Kennedy* (1981), 33 OR (2d) 497 (CA).

requirement has also been codified into statute in many provinces and forms a part of the codes of ethical conduct for all health care professionals. Respect for persons — the ethical imperative — requires that each person is valued and treated as an end in himself or herself, not merely as means to the ends of other people.

In 1995, Health Canada convened a national conference that established a consensus on guidelines for a protocol to notify emergency responders when they may have been exposed to an infectious disease.[32] In 1996, Health Canada convened a meeting establishing a protocol for managing exposure to HBV, HCV and HIV among health-care workers.[33] Both reiterated that informed consent must be obtained for testing the source person.[34]

Manitoba's *Integrated Post-Exposure Protocol* emphasizes voluntary testing and the informed consent, for both the exposed person and the source person.[35] Specifically, it states that:

> Informed consent must be obtained prior to all testing. It may be given verbally rather than in writing, but this should be recorded. For the Source person, consent should include permission to make the test results available to the Exposed. The Exposed should not become involved in obtaining consent from the Source.[36]

Similarly, the Canadian Medical Association Code of Ethics advices physicians that "[i]f a service is recommended for the benefit of others, as for example in matters of public health, inform the patient of this fact and proceed only with explicit informed consent or where required by law."[37]

The qualified benefits of forced testing, examined above, are not sufficient to rationalize the serious legal and ethical violation that

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[32] Health Canada. A national consensus on guidelines for establishment of a post-exposure notification protocol for emergency responders. *Canada Communicable Disease Report* 1995; 21(19): 169-175.

[33] Health Canada. An integrated protocol to manage health care workers exposed to bloodborne pathogens. *Canada Communicable Disease Report* 1997; 23 (Suppl 23S2): 1-14.

[34] A discussion paper written by ULCC member Prof. Wayne Renke argues that the Health Canada protocol is ineffective because its disclosure provisions are not broad enough to cover all cases of occupational exposure. However, this approach ignores the fact that Health Canada has rightly adopted an informed consent approach to situations of occupational exposure. See W Renke. *Communicable Disease Exposure and Privacy Limitations: Issues Paper*. Uniform Law Conference of Canada. 2003. Avalable via www.ulcc.ca.

[35] *Integrated Post-Exposure Protocol: Guidelines for Managing Exposures to Blood/Body Fluids*, at ss 6, 7, 11.

[36] Ibid., at s.7.

[37] *CMA Code of Ethics*, (Update 2004), para. 23.

occurs when the requirement of informed consent for a medical procedure is set aside.

4.2 Human rights concerns under the *Charter*

Forced testing legislation raises numerous human rights concerns under the *Canadian Charter of Rights and Freedoms*. **In our submission, the government violates the *Charter* if it authorizes HIV testing without consent. In particular, it infringes the rights to liberty and security of the person (section 7) and the right to be free from unreasonable seizure (section 8).** A person's right to privacy is reflected in both of these constitutional guarantees.

We look at each of these considerations below. We then address the question of whether these infringements of constitutionally-guaranteed human rights can be justified.

<u>The rights to liberty and to security of the person</u>

First, forcibly subjecting a person to a medical procedure without his or her consent amounts to an infringement of his or her security of the person. To have your blood drawn against your express wishes represents the quintessential harm against which the *Charter* right is to provide some protection. **If the state is to exercise its coercive power in this way to infringe basic human rights, it must have a strong justification for doing so.** Under the *Charter* the state must show that a violation of the right to liberty or security of the person is consistent with the basic principles of our legal system and is demonstrably justified in our free and democratic society (see below the discussion of whether this violation of constitutional rights is justified).

Second, if the proposed legislation provides that a source person who refuses to comply with an order to provide a blood sample for testing is guilty of an offence, the legislation would criminalize people for asserting their legal right to bodily integrity and informed consent. Furthermore, if the legislation permits medical officers of health to enlist the aid of peace officers to compel testing in the face of a refusal to comply with the court's order, further infringements of both liberty and security of the person would ensue in forcibly detaining a person and drawing blood.

<u>The right to physical privacy also protects bodily and psychological integrity</u>

The Supreme Court ruled has ruled, in the *Dyment* case, that

> the use of a person's body without his consent to obtain information about him invades an area of personal privacy essential to the maintenance of human dignity... [T]he protection of the *Charter* extends to prevent a police officer, an agent of the state, from taking a substance as intimately personal as a person's blood from a person who holds it subject to a duty to respect the dignity and privacy of that person."[38]

In *Dyment*, police had obtained without patient's consent a sample of free-flowing (not drawn) blood obtained by a physician treating a man involved in an automobile accident. The Supreme Court ruled this was an unlawful seizure in breach of section 8 of the *Charter* and that the violation of the man's privacy interests were not minimal.

The Court had said previously in one of the leading cases on section 8 of the *Charter*,[39] and reiterated in *Dyment*, that the function of the *Charter* "is to provide…for the unremitting protection of individual rights and liberties" and that a major purpose of the constitutional protection against unreasonable search and seizure is the protection of the privacy of the individual. Furthermore, that right "must be interpreted in a broad and liberal manner so as to secure the citizen's right to a reasonable expectation of privacy against governmental encroachments."[40] **The Supreme Court has since reiterated: "That physical integrity, including bodily fluids, ranks high among the matters receiving constitutional protection, there is no doubt…"**[41]

There has been only one reported case in Canada directly considering the question of whether a court may order HIV testing of a person against his or her will, and provide the test results to a person claiming to have been exposed to a risk of infection.[42] In this case, a woman sought an order that the man accused of sexually assaulting her provide a blood sample for HIV testing.[43] The order was refused. The court, a Quebec trial court, expressly referred to the Supreme Court's decision in *Dyment* and noted that forced testing raises serious *Charter* concerns.

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[38] *R v Dyment*.

[39] *Hunter* v. *Southam*, [1984] 2 SCR 145 at 155.

[40] *Dyment*, at 426. In the earlier case of *R v Pohoretsky*, [1987] 1 SCR 945, the Court stressed the seriousness of a violation of the sanctity of a person's body as an affront to dignity.

[41] *R* v. *Colarusso*, [1994] 1 SCR 20 at 53.

[42] There have been other cases in which a request for a testing order has ultimately been agreed to by the accused (e.g., in the case of Paul Bernardo), so the issue of the constitutionality of forced HIV testing has not been judicially analysed in those cases.

[43] *R* c. *Beaulieu*, [1992] AB No. 2046 (Cour du Québec – Chambre criminelle).

Taking bodily samples without consent is clearly the exception in Canadian law. Indeed, the *Criminal Code* only allows it in two carefully limited circumstances — that is, testing for alcohol when there are reasonable grounds to believe an offence of impaired driving has been committed and for the purpose of DNA analysis relating to a prosecution for certain designated serious offences. In both of those circumstances, the infringement of privacy has been deemed justified in the interests of law enforcement once reasonable grounds exist for believing a person has engaged in criminal wrongdoing.

Forced blood testing legislation such as that proposed for Manitoba would authorize medical tests on people without their consent, without any requirement that there be at least a *prima facie* case of wrongdoing. Compulsory testing could be ordered for a person who has not been arrested or charged with any criminal or quasi-criminal offence. Under this legislation, an accident victim found unconscious by the roadside could be ordered to be tested for HIV, HCV and/or HBV if an emergency responder had broken skin that came into contact with the victim's blood. Someone injured in a domestic assault could be compelled to be tested for these viruses if a healthcare worker accidentally stuck him or herself with a needle while treating her injuries. Any patient receiving health care services could be the subject of an order for compulsory testing.

The violation of physical privacy and bodily integrity is compounded by a violation of psychological integrity by removing for the source person the option to decide whether and when to get tested in accordance with their own personal circumstances.

Informational privacy

Two years after the *Dyment* decision, the Supreme Court ruled in the *Duarte* case that the *Charter* protects the right of an individual to determine for himself or herself when, how, and to what extent they will release personal information about themselves.[44]

It may be hard for many to imagine why someone might refuse testing. Indeed most people consent to testing in circumstances of occupational exposure, and knowing one's serostatus allows a person to access potentially lifesaving treatments and modify his or her behaviour so as not to infect others. But **there are indeed good reasons why people do not wish to be tested.** The loss of confidentiality about something as significant as HIV status can produce a whole range of negative consequences.

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[44] [1990] 1 SCR 30 at 46.

Stigma and discrimination related to a disease like HIV/AIDS are a reality in Canada.[45] For example, discrimination in employment, services, accommodation and membership in social or professional associations persists for people known or perceived to be HIV-positive (or to have hepatitis). A victim of domestic assault who tests HIV-positive faces the prospect that public health authorities would notify his or her partner of the partner's possible past exposure.

It is questionable whether the privacy protection afforded in forced testing legislation can ever be more than illusory.

First, **evidence of someone's HIV-positive status can find its way into evidence in court proceedings.** Once the source person's status is known, that information is compellable from them under oath in another proceeding. A province does not have the constitutional jurisdiction to declare evidence inadmissible in a criminal proceeding. Consequently, provincial legislation authorizing forced HIV testing could result in evidence that could be used against a source person in a criminal proceeding — a violation of the constitutional right against self-incrimination.[46] Such an outcome would compound the original violations of the source person's constitutional rights to liberty, security of the person and privacy (including the right to be free from unreasonable search and seizure).

Second, the very purpose of forced testing legislation is to inform an exposed person of the source person's serostatus. Requiring confidentially on the part of those carrying out responsibilities associated with the provisions of the legislation, such as the public health officer, peace officer, health care workers and analysis is of limited value. **The source person's identity and HIV test result are communicated to the exposed person. Even if the law may state that the exposed person is not allowed to disclose this information to others, this is likely to be unenforceable in practice.** One can understand the desire to share this information with family, friends and co-workers with whom the fact of the initial exposure has likely already been discussed. Those people may in turn discuss this information with others, with the result that the source person's HIV-positive status could become widely known. The invasion of the source person's privacy would be particularly acute in a smaller community. **In reality, it is practically impossible to legislate any effective confidentiality protection for a source person who has been**

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[45] See: (1) Series of info sheets on "HIV/AIDS and discrimination"; (2) T de Bruyn. *HIV/AIDS and Discrimination: Final Report*. Canadian HIV/AIDS Legal Network. 1998; (3) T de Bruyn. *A Plan of action for Canada to reduce HIV/AIDS-related stigma and discrimination*. Canadian HIV/AIDS Legal Network. 2004. All documents are available on-line via www.aidslaw.ca/discrimination..

[46] The constitutional right against self-incrimination is based in sections 7, 11(c) and 13 of the *Charter*.

forcibly tested for HIV, just as the law will be able to do little to protect against HIV/AIDS-related stigma that will follow.

Two decades of experience show that breaches of confidentiality are commonly experienced by people living with HIV, particularly in small or closely knit communities, and that the consequences can be devastating. In most cases, there is no effective, accessible remedy.[47]

Prior judicial authorization dubious as a safeguard for *Charter* rights

Some of the forced testing legislation that exists in other jurisdictions includes a requirement of prior judicial authorization for compulsory testing orders. Certainly it is important that there be some such scrutiny of the legitimacy of the request before people are subjected to testing without their consent. Yet the safeguard of prior judicial authorization does not adequately protect every *Charter* right implicated.

The requirement of judicial authorization does not necessarily address concerns about the right to privacy. Experience to date indicates media interest in reporting cases of occupational HIV exposure of police officers and emergency responders. An application for compulsory testing would likely attract media attention and risks leading to the publication of the names or other identifying information about the source person in the course of reporting on the court proceeding.

Furthermore, some forced testing legislation contemplates that the requirement to notify the source person of an application for a testing order may be dispensed with in certain circumstances. This opens the door to an agent of the state (i.e., a court) issuing orders allowing for forced testing of people without giving them a chance to oppose the order.

Rights violations cannot be justified

In the leading *Oakes* case,[48] the Supreme Court of Canada set out the requirements for justifying legislation that infringes *Charter* rights under the provisions of section 1 of the *Charter*:

- the objective to be served by the measures infringing the right must relate to concerns that are "pressing and substantial in a "free and democratic society";

[47] See generally *Privacy Protection and the Disclosure of Health Information: Legal Issues for People Living with HIV/AIDS in Canada*. Montréal: Canadian HIV/AIDS Legal Network, 2002-2004. Available online via www.aidslaw.ca/privacy.

[48] *R v Oakes*, [1986] 1 SCR 103.

- the measures must be fair and not arbitrary, carefully designed to achieve the objective in question, and rationally connected to that objective;
- the measures should impair the Charter right as little as possible; and
- there must be proportionality between the effects of the limiting measure and the objective - the more severe the infringement of the right, the more important must be the objective.

We agree that protecting people against occupational and non-occupational exposures to blood-borne pathogens, and helping them deal with the aftermath of such an exposure, are pressing and substantial concerns. This is why the **Legal Network supports, as a matter of workers' human rights, measures to prevent or reduce the risks of occupational exposures in the first place, and prompt and adequate information, counselling, support, accommodation and treatment in the event that exposures do occur. However, we submit that forced testing legislation such as that being proposed in Manitoba fails each of the remaining three steps required to justify a violation of *Charter* rights** (i.e., the *Oakes* test under section 1 of the *Charter*).

Forced testing for blood-borne pathogens is not rationally connected to, nor does it achieve, the legislative objectives. After the fact testing for HIV, HBV or HCV does not protect against the occurrence of exposures involving emergency responders and health care workers. It does not make workplaces safer environments. Providing emergency responders and health care workers with a procedure to test a source person for HIV does not ensure that the source person's HIV status can be definitively determined during the time in which this information is crucial for making a decision about post-exposure prophylaxis (ideally within 2 to 4 hours).

As for addressing anxiety post-exposure, **providing emergency responders with basic information about HIV transmission, accurate information about the risks involved in different types of exposures, and appropriate counselling resources would be more effective. Various leading associations of health professionals have criticized this sort of legislation as "not warranted" or "unjustified."**[49] We have noted in detail above and in the *Backgrounder* that the rationale for authorizing compulsory testing for HCV and HBV is not borne out by the medical and scientific evidence.

[49] As set out in the *Backgrounder*, at 25 to 31, the groups include Canadian Nurses Association, the Canadian Association of Nurses in AIDS Care, and the Canadian Medical Association.

We submit that forced testing legislation impairs *Charter* rights in considerably more than a minimal fashion, for the reasons set out above, including:

- the application of physical force to conduct a medical procedure without consent;
- the invasions of physical, psychological and informational privacy represented by compulsory testing;
- the practical impossibility of legislating adequate protection for the confidentiality of the test results of the person subject to compulsory testing, or of creating any effective remedy once the damage of testing without consent has been done;
- the potential negative ramifications that will or will likely follow for the person who tests positive (particularly for HIV) as a result of compulsory testing; and
- the viable alternatives for managing occupational (and non-occupational) exposures that seek to address many of the concerns and needs of exposed persons without infringing the constitutional rights of alleged source persons.

Finally, we submit that the requisite proportionality between objectives and infringement of *Charter* rights is not adequately demonstrated. Infringement of constitutional rights – liberty, security of the person, privacy (including freedom from unreasonable search and seizure), and possibly even the right against self-incrimination – is not warranted if it is unnecessary to achieve the legislative objectives. **If the benefit to the exposed person is limited, and the potential negative consequences to the forcibly tested person are significant, compulsory testing legislation is not constitutionally justifiable. Workers who risk exposure to blood-borne pathogens such as the Hepatitis B and C viruses and HIV deserve a more considered, comprehensive response from legislators, which offers them real protection against infections to which they may be exposed. Ensuring access to adequate information, counselling, support and treatment in the event of an exposure is more beneficial to emergency responders and represents more a constructive and useful alternative.**

4.3 Consistency in the law: an important policy consideration

Proposals such as the one being proposed in Manitoba also raise the issue of consistency in the law, which is desirable as a matter of public policy. This legislation would authorize the compulsory testing of a source person in the event that an emergency responder or health care worker is exposed in the course of their duties, and potentially if a Good Samaritan

were exposed in the course of assisting another. But what if the emergency responder or health care worker exposes the other person to the risk of infection? The same rationales about obtaining information to make post-exposure prophylaxis decisions, prevent secondary transmission and alleviate anxiety would surely apply in those circumstances.

We are faced, then, with the prospect of authorizing the compulsory testing of emergency responders, health care workers and Good Samaritans — or, indeed, authorizing compulsory testing following any significant exposure of one person by another. This question was raised by representatives of Justice Canada before the House of Commons Standing Committee with respect to similar forced testing legislation, which legislation that Committee ultimately recommended not proceed.[50]

[50] Yvan Roy, Senior General Counsel, Criminal Law Policy Section, Justice Canada. Evidence to House of Commons Standing Committee on Justice and Human Rights, 13 June 2000.

5. Conclusions and recommendations

Forced blood testing legislation, as is being proposed in Manitoba, offers few benefits to emergency responders and health care workers potentially exposed to HIV, HBV and/or HCV in the course of their duties, but raises serious constitutional concerns. As detailed in this submission, legislation of this sort is a flawed response to the real anxiety and health concerns of those potentially exposed to blood-borne infections. Misinformation about the true risks of infection and the limited benefit of test results compelled under legislation of this sort often motivate calls for legislation of this sort.

The rights of source persons deserve protection, and the very real negative consequences that can flow from compelled blood testing should give legislators pause when confronted with this bill. Testing source person's blood without consent, as contemplated in the forced testing legislation, is not a balanced, effective response to this issue.

Given the limited benefits and considerable risks posed by this policy approach, the Canadian HIV/AIDS Legal Network urges the Government of Manitoba and all parties in the Legislative Assembly not to adopt this legislation.