CANADIAN HIV•AIDS LEGAL NETWORK | RÉSEAU JURIDIQUE CANADIEN VIH•SIDA

After *Cuerrier*:

Canadian Criminal Law and the Non-Disclosure of HIV-Positive Status

Health Canada Santé Canada

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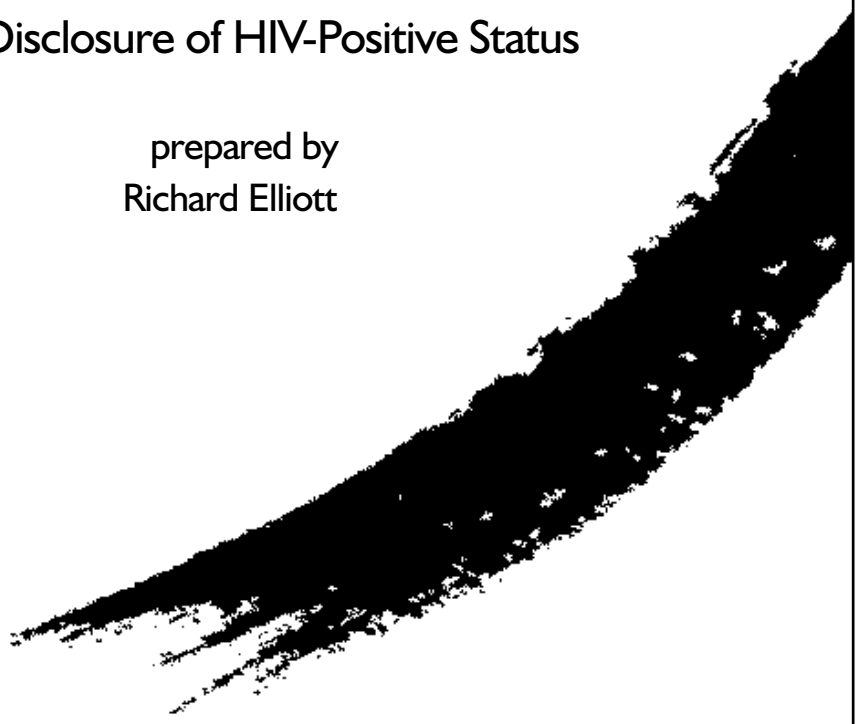
prepared by
Richard Elliott



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After Cuerrier:
Canadian Criminal Law and the Non-Disclosure of HIV-Positive Status

Prepared by
Richard Elliott
for the Canadian HIV/AIDS Legal Network

For further information about this publication, please contact:

Canadian HIV/AIDS Legal Network
484 McGill Street, 4th Floor
Montréal, Québec H2Y 2H2
Tel: (514) 397-6828
Fax: (514) 397-8570
Email: info@aidslaw.ca
Website: www.aidslaw.ca

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Important Note
The information in this paper is not legal advice. People who have questions about whether they or someone they know has a duty to disclose or is risking criminal prosecution should consult a criminal lawyer familiar with HIV/AIDS issues.

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Executive Summary

Background

In September 1998, the Supreme Court of Canada released its judgment in *R* v *Cuerrier*, the first case to reach the highest court that dealt with a criminal prosecution of an HIV-positive person for engaging in sexual activity without disclosing their serostatus. Overruling lower-court decisions, the Supreme Court ruled that where sexual activity poses a "significant risk of serious bodily harm," there is a duty on the HIV-positive person to disclose their status. Where this duty exists, not disclosing may constitute "fraud" that renders a sexual partner's consent to that activity legally invalid, thereby making the otherwise consensual sex an "assault" under Canadian criminal law.

Concerns have been raised (including before the Court in *Cuerrier*) about imposing criminal sanctions on those who do not disclose their HIV-positive status and engage in risky activity. In particular, there is concern that, among other detrimental effects, such a policy will deter people (particularly people at higher risk) from getting tested, as well as impede education and undermine counseling efforts to assist with changing behaviour to reduce the risk of transmission. The Supreme Court acknowledged that education and interventions by public health authorities are available to respond to such conduct, but ruled that the criminal law has a deterrent role to play when public health efforts are unsuccessful.

The Goals of the Paper

In light of the decision in *Cuerrier* and the questions raised by it, the Legal Network undertook to prepare a detailed analysis of the decision in order to:

- assist people with HIV/AIDS, AIDS service organizations and other community-based organizations, health-care workers, lawyers and legal workers, public health officials, and others in understanding what the decision does and does not mean, and what it may and could mean in a number of contexts; and
- to provide recommendations to policy- and decision-makers such as government and public health officials, prosecutors, police, legislators, and the judiciary as to how *Cuerrier* should – and should not – be interpreted and applied, so as to minimize the potential negative consequences of the decision on people with HIV/AIDS, on HIV prevention efforts in Canada, and on the provision of care, treatment, and support to people with HIV/AIDS.

The Content of the Paper

The Paper provides an overview of the *Cuerrier* decision. Based on the judgment, the Paper then attempts to provide some answers (where possible) as to when an HIV-positive person may risk criminal prosecution if they do not disclose their status, looking at the possibility of HIV transmission through sexual activity, transmission through sharing drug injection equipment, mother–infant transmission, and transmission through invasive medical procedures. The Paper analyzes whether *Cuerrier* does or should apply in these different contexts. Where the conclusion is that *Cuerrier* is applicable, the Paper also considers how the decision applies, as well as indicating how it should not be applied.

Disclosure by people with HIV/AIDS

Sexual activity

The Supreme Court ruled that disclosure of HIV-positive status is required by the criminal law before one engages in sexual activity that poses a "significant risk" of transmitting HIV. As a result of the Court's decision, it is clear that unprotected vaginal or anal intercourse poses a "significant" risk for the purpose of the criminal law.

However, the Court also suggests that "careful use of a condom" may lower the risk sufficiently that it is no longer "significant" and therefore disclosure would not be required. While this remains unsettled in the law, people with HIV/AIDS face uncertainty about the obligations imposed by the law, upon pain of criminal prosecution. The Paper recommends that this defence of practising "safer sex" be expressly recognized by courts in subsequent cases, so as to provide a more manageable alternative to disclosure that still significantly reduces the risk of HIV transmission and protects the HIV-positive person from criminal prosecution. Criminalizing even the HIV-positive person who takes precautions to protect a sexual partner would remove any incentive to practise safer sex, and would be in direct contradiction to the crucial public health message to take such precautions.

The Paper also urges that the justice system take a contextual approach to assessing the "dishonesty" of not disclosing HIV-positive status, so as to acknowledge that disclosure is not always easily made, and in some circumstances may carry serious risk of physical or other kinds of violence.

However, no firm legal conclusion can be drawn as to whether the law will develop in this way.

Sharing drug injection equipment

While the *Cuerrier* case dealt with non-disclosure of HIV-positive status before engaging in unprotected sex, the Paper concludes that the principles set out in *Cuerrier* likely directly apply to the situation where someone, using injection equipment they know to have been previously used by an HIV-positive person (such as themselves), directly injects another person without informing them of this fact. (Other criminal charges might be laid where an HIV-positive person does not directly inject their partner, but knowingly lets another person use their equipment without disclosing their status.)

The Paper notes that it is unclear whether, like using a condom for sex, simply cleaning injection equipment on its own will be considered as sufficiently lowering the risk below the level of "significant" so that disclosing HIV-positive status is not required before injecting a drug-use partner with the same "works." The Paper also acknowledges that it is unclear whether simply disclosing HIV-positive status, before injecting a drug-use partner with the same equipment, would be sufficient to ensure that their consent to being injected is legally valid. Courts could, for public policy reasons, refuse to accept that a person can consent to being injected with uncleaned equipment containing blood from an HIV-positive person, even if they were aware of their partner's status. While these questions remain unsettled in the law, the Paper recommends that there should at least be no criminal liability on the person who both discloses their status and cleans their equipment before another person is injected with it. The Paper also suggests that a contextual approach again be adopted, to acknowledge that in some circumstances (eg, imprisonment) an HIV-positive drug user not only may face serious consequences upon disclosing their status, but also has no access to sterile injection equipment and is therefore forced to rely upon cleaning equipment, following standard public health advice where the safer option of avoiding sharing is not available.

Mother–infant transmission

Cuerrier provides no basis for criminal liability for HIV transmission from mother to child during pregnancy or delivery. However, because of the uncertainty regarding the degree of risk of transmitting HIV through breast-feeding, a broad interpretation of the *Cuerrier* decision might lead to the conclusion that an HIV-positive mother who breast-feeds her infant could be prosecuted for assault for exposing the child to a "significant" risk of infection. Given the epidemiological and legal uncertainty of this question, the Paper recommends that HIV-positive mothers need to be counseled to refrain from breast-feeding and that governments and responsible parties need to ensure that HIV-positive mothers have the information and necessary supports (including financial assistance) to ensure access to breast-milk substitutes.

Transmission via invasive medical procedures

Given that many medical procedures involve physical contact between patient and health-care worker, applying the *Cuerrier* decision in a health-care context means that a criminal charge of assault could likely be sustained where an HIV-positive health-care worker does not disclose their status to a patient

before engaging in a procedure carrying a "significant" risk of transmission, because the patient's consent to that procedure could be said to be vitiated (rendered legally invalid) by the non-disclosure. Similarly, an HIV-positive patient could be subject to the same duty to disclose where the procedure posed a "significant" risk of transmission to the health-care worker.

However, the Paper concludes that the use of universal precautions should more than suffice in almost all circumstances to sufficiently reduce any risk of HIV transmission. In such cases, there should be no "significant" risk, and the Paper recommends that there should therefore be no duty (under the criminal law) to disclose HIV-positive status.

The Paper concludes that it is only in the case of "exposure-prone procedures," which carry a "significant risk" of transmission, that there may be a duty to disclose. The Paper does not take up the debate over which procedures should be considered to fall into this category, but concludes that *Cuerrier* may impose criminal liability on the HIV-positive person (health-care worker or patient) who does not disclose their status before such a procedure. However, the Paper offers a reasoned prediction that HIV-positive health-care workers who follow existing, established professional guidelines regarding universal precautions, and expert advice regarding "exposure-prone procedures," likely need not worry about possible criminal prosecution, as they will not have engaged in activities that are considered to pose a "significant" risk of transmission. As this is not clearly established in the law, the Paper recommends this position to prosecutors and the judiciary, should they be called upon in future to consider the application of *Cuerrier* to the medical context.

The Paper also concludes that *Cuerrier* does not require professional bodies to revise their policies or guidelines with a view to making them more restrictive with regard to HIV-positive health-care workers.

Cuerrier and public health law, policy, and practice

The *Cuerrier* case only speaks to the question of whether and when an HIV-positive person has a duty to disclose their status because of a risk to others. However, questions have also been raised about what the decision means for public health authorities.

The Paper confirms that *Cuerrier* does not change existing legal obligations in the field of public health practice. The basic principles governing pre- and post-test counseling and partner notification remain the same. However, the Paper recommends that counseling must incorporate accurate information about the *Cuerrier* decision and the possibility of criminal charges for engaging in activity posing a "significant" risk of transmission without disclosing.

Cuerrier highlights the importance of ensuring that public health interventions continue to be conducted on the principle of a graduated response (ie, "least intrusive, most effective" measures to be tried first), that such measures be fully explored before resort is had to the criminal law, and that there be adequate procedural safeguards in place against the misuse of coercive public health measures. The Paper recommends that prosecutors consult with public health authorities before laying or pursuing criminal charges to determine whether measures under public health legislation offer an alternative to prosecution.

Disclosure of confidential information compelled by law

The *Cuerrier* case has also raised questions (albeit not for the first time) about the confidentiality of information about a person's HIV-positive status and/or conduct that risks transmitting the virus.

The Paper confirms that the *Cuerrier* decision does not affect the obligation to report HIV/AIDS diagnoses under applicable public health law.

Nor does it alter or expand any common law "duty to warn" someone known to be at risk of HIV infection as a result of information gained through a confidential relationship. The Paper notes that it is unclear in Canadian law whether a community-based organization (or, for example, a counselor working in such an organization) would be found liable for negligence if they did not breach the confidentiality of their relationship with an HIV-positive person in order to warn a sex or needle-sharing partner to whom they had not disclosed their status. However, organizations may wish to consider obtaining legal advice and drafting policy to guide counselors or others who may face this difficult question.

The Paper also notes that disclosure of confidential information about a person's HIV-positive status and/or conduct that risks transmission to others may be compelled by search warrant or subpoena for use in a criminal prosecution. Information held by a community-based organization serving people with HIV/AIDS may be sought for such purposes. The Paper therefore recommends that community-based organizations ensure that those to whom they provide support services (eg, counseling) be made aware of this possibility before revealing information that may constitute evidence of criminal activity. The Paper also recommends that organizations, with the assistance of legal advice, consider developing some policies (especially for counseling staff and volunteers) for dealing with confidential information about a person's HIV status or risk activities, and the disclosure of that information. Such a policy could include a protocol for responding to prosecutors requesting confidential information or police executing a search warrant.

Introduction

Background

In its September 1998 judgment in the case of *R* v *Cuerrier*,[1] the Supreme Court of Canada unanimously decided that an HIV-positive person *may* be guilty of the crime of "assault" if they do not disclose their HIV-positive status before engaging in unprotected sexual activity.

Before *Cuerrier*, trial and appellate courts in Canada and other countries (including the US, the UK, Australia, Switzerland, Finland, and France) had heard cases in which HIV-positive persons faced charges under criminal or public health laws for engaging in activity that transmitted or risked transmitting HIV. In some cases, criminal prosecution has been based on conduct that was merely perceived as risking transmission. Convictions and prison sentences have been imposed in some of those cases.[2] However, the *Cuerrier* case represents the first time any country's highest court has addressed the issue of criminal sanctions for conduct that risks transmitting HIV. The decision also represents the first time in Canada that an HIV-positive person has been convicted for the offence of *assault* for not disclosing their serostatus before engaging in otherwise consensual sex. The Supreme Court's decision received considerable media attention and commentary.

Numerous people with HIV/AIDS, and individuals and organizations working with and for HIV-positive people and people "at risk," have expressed concerns about criminally prosecuting people for not disclosing their HIV-positive status.[3] The *Cuerrier* decision raises several questions for people with HIV/AIDS about disclosure and their sexual lives. It may also have ramifications for risky conduct in areas other than sexual activity. Finally, as a result of the *Cuerrier* case, some have again raised questions about what such criminal prosecutions may mean for people or organizations who come into

[1] (1998), 127 CCC (3d) 1 (SCC), rev'g (1996), 111 CCC (3d) 261, 141 DLR (4th) 503 (BCCA), 3 CR (5th) 330, 136 WAC 295, 83 BCAC 295, 33 WCB (2d) 4, [1996] BCJ No 2229 (QL), aff'g 26 WCB (2d) 378 (BCSC).

[2] For a summary of some of these cases, see R Elliott. *Criminal Law and HIV/AIDS: Final Report*. Montréal: Canadian HIV/AIDS Legal Network & Canadian AIDS Society, 1997; Criminal Law and HIV/AIDS Info Sheet 3: Canadian Criminal Cases and HIV. Montréal: Canadian HIV/AIDS Legal Network, 1999; and other articles on criminal law and HIV/AIDS in the *Canadian HIV/AIDS Policy & Law Newsletter*.

[3] See Elliott, supra, note 2, and B Bell. *Legal, Ethical, and Human Rights Issues Raised by HIV/AIDS: Where Do We Go From Here? Planning for 1998-2003: A Planning Report*. Montréal: Canadian HIV/AIDS Legal Network, January 1999. For an overview of various aspects of criminal law and HIV/AIDS in Canada, see also Criminal Law and HIV/AIDS Info Sheets 1-8. Montréal: Canadian HIV/AIDS Legal Network, 1999.

possession of information about an HIV-positive person's serostatus or their conduct that may risk transmitting the virus.

Goals of the Legal Network Project on *Cuerrier*

In the fall of 1998, national consultations were held to provide direction to Health Canada regarding priorities for the "legal, ethical, and human rights" component of the Canadian Strategy on HIV/AIDS. In those consultations, people across the country raised questions and concerns about the significance of the *Cuerrier* decision.[4]

The Legal Network therefore undertook the task of preparing this careful analysis of the case, with two goals:

- to assist people with HIV/AIDS, AIDS service organizations and other community-based organizations, health-care workers, lawyers and legal workers, public health officials, and others in understanding the what the decision does and does not mean, and what it may and could mean in a number of contexts; and
- to provide recommendations to policy- and decision-makers such as government and public health officials, prosecutors, police, legislators, and the judiciary as to how *Cuerrier* should – and should not – be interpreted and applied, so as to minimize the potential negative consequences of the decision on people with HIV/AIDS, on HIV prevention efforts in Canada, and on the provision of care, treatment, and support to people with HIV/AIDS.

Many of those consulted expressed the concern that misinterpretation of the *Cuerrier* decision might lead to it being incorrectly applied in ways detrimental to HIV-positive people and to public health generally.

Activities Undertaken

In February 1999, a national workshop was held in Toronto to discuss a draft paper analyzing the *Cuerrier* decision and its possible implications. Comment was also sought from others who did not participate in the workshop discussions. Participants in the consultation process were given a further opportunity to comment on the final draft of the Paper before publication.

Many of those consulted expressed the concern that misinterpretation of the *Cuerrier* decision might lead to it being incorrectly applied in ways detrimental to HIV-positive people and to public health generally. Some experiences following the decision that were reported at the workshop confirm that this is cause for concern. In particular, there was concern that:

- the decision was being interpreted in an overly broad fashion, with the result that HIV-positive people and others were not receiving accurate information about when non-disclosure may carry the risk of a criminal prosecution; and
- the decision might be incorrectly taken as affecting the law, policy, or practice in areas outside the criminal law regarding the disclosure of a person's serostatus. It was therefore recommended that the Paper go beyond an analysis of the decision itself and how it might affect criminal prosecutions for risky activity other than sex. It was recommended that the Paper also address this possible "ripple effect" in other areas of law, policy, or practice.

This input helped identify the legal and policy areas in which *Cuerrier*'s possible impact needs to be carefully analyzed, and those areas in which *Cuerrier* has no application and should not be taken as having any application.

[4] Bell, supra, note 3.

The Scope of the Paper

In light of the number of questions raised by the *Cuerrier* decision, and the input received at the national workshop, the scope of the Paper has expanded significantly beyond what the Legal Network had originally contemplated would be addressed by this project.

In "The Case: *R* v *Cuerrier*," the Paper provides an overview of *R* v *Cuerrier*, identifying the key points and passages of the Supreme Court's decision. The gist of the two minority judgments is also provided. The markedly different approaches taken by the justices highlight the difficulty of applying the criminal law of assault in a principled fashion to conduct that risks transmitting HIV. The justices' critiques of each other's positions are also useful in articulating the shortcomings of each approach and in predicting how areas of uncertainty may be dealt with in future cases.

In "Disclosure of Serostatus by People with HIV/AIDS," the Paper takes up the question of when an HIV-positive person risks (or may risk) criminal prosecution if they do not disclose their HIV-positive status. The Paper looks at different circumstances under which transmission might occur: sexual activity, sharing drug injection equipment, mother–infant transmission, and transmission through invasive medical procedures. The Paper analyzes whether *Cuerrier* does or should apply in these different contexts. Where the conclusion is that *Cuerrier* is applicable, the Paper also considers how the decision applies, as well as indicating how it should not be applied.

In "Public Health Law, Policy, and Practice" and "Disclosure of Confidential Information Compelled by Law," the Paper discusses some questions that, while they do not directly deal with the question of criminal liability, have been raised in response to the *Cuerrier* decision and which it was therefore thought should be addressed.

The Paper confirms, in the first of these two chapters, that the *Cuerrier* decision does not alter existing obligations under public health laws, although information about the decision should be incorporated into public health practice. Furthermore, the decision highlights the importance of a graduated response in the use of coercive public health powers, the use of such interventions before resorting to criminal prosecution, and the need for adequate procedural safeguards against the misuse of coercive powers under public health legislation.

In the second of these chapters, the Paper addresses three circumstances in which there may be an ethical and/or legal obligation to breach confidentiality about a person's HIV-positive status. First, the Paper confirms that existing HIV/AIDS reporting obligations under public health statutes are not altered by *Cuerrier*. Second, the Paper confirms that *Cuerrier* does not expand existing ethical or legal obligations to breach confidentiality about a person's HIV-positive status if their conduct risks transmitting HIV to someone else, and should not be interpreted as having this effect. Third, the Paper discusses the compelled disclosure by search warrant or subpoena of information about the serostatus and/or conduct of HIV-positive people that risks HIV transmission. The Paper recommends that those working with people with HIV/AIDS (eg, AIDS service organizations) who have not yet done so should consider developing policies or protocols for dealing with confidential information regarding individuals' HIV status and risk activities.

The "Conclusion" follows, reiterating the caution against an unwarranted and overly broad interpretation of *Cuerrier*. Finally, there is a "Summary of Recommendations" made throughout the paper.

This Paper does not provide a fully detailed analysis of every possible nuance of the *Cuerrier* decision or of the possible applications of the criminal law to every circumstance in which conduct may risk HIV transmission. There are many questions left unanswered by the *Cuerrier* case. Future legal and policy developments cannot be predicted with certainty. It remains to be seen how this development in Canadian criminal law will play itself out in future legal proceedings.

Nor does the Paper provide a comprehensive review of the current state of Canadian criminal law relating to HIV/AIDS. The Paper should be read in conjunction with *Criminal Law and HIV/AIDS: Final Report*,[5] which examines the arguments in favour and against criminalization of activity that risks transmitting HIV; considers whether measures available under public health legislation offer a preferable alternative to using the criminal law; and analyzes in detail the various provisions of the *Criminal Code* that have been used to prosecute people for conduct that transmits or risks transmitting HIV. Reference should also be had to *HIV Testing and Confidentiality: Final Report*,[6] which contains further discussion relevant to several issues touched on in this Paper, such as informed consent to HIV testing, pre- and post-test counseling, testing and disclosure by health-care workers, disclosure to prevent harm to others, reporting obligations, and partner notification.

Next Steps

The Legal Network will widely distribute the final Paper and make it available on the Internet; update and distribute a series of info sheets on the issue of criminal law and HIV/AIDS (including the *Cuerrier* decision) targeting a variety of interested groups; make presentations at conferences about the issues discussed in the Paper and its conclusions and recommendations; undertake other activities in line with those conclusions and recommendations, including following up with governments, policymakers, and others to whom the recommendations are directed; and continue to monitor developments in the area of HIV/AIDS and criminal law in Canada.

[5] Supra, note 2.

[6] R Jürgens. *HIV Testing and Confidentiality: Final Report*. Montréal: Canadian HIV/AIDS Legal Network & Canadian AIDS Society, 1998.

The Case: *R* v *Cuerrier*

The Facts

In August 1992, Cuerrier was told by a public health nurse that he was HIV-antibody positive, and that he should use condoms for sex and tell his sexual partners about his HIV-positive status. He said he could not disclose this in his small community. Soon after, he began a relationship with KM, including frequent unprotected vaginal sex. Sometime either before, or within a week of, their first sexual encounter,[7] KM discussed sexually transmitted diseases (STDs) with Cuerrier. He told her of his recent sexual encounters with women who themselves had had numerous partners. KM did not specifically ask about HIV. Cuerrier told her he had tested HIV-negative several months earlier, but did not mention his recent positive test result. KM said at trial that she knew the risks of unprotected sex, including HIV and other STDs.

A few months later, both Cuerrier and KM had HIV-antibody tests. He tested HIV-positive; she tested HIV-negative. Both were told of Cuerrier's infection, and advised to use condoms for sex. KM was told she would need further tests because she might still test HIV-positive. Cuerrier said he did not want to use condoms, and that if KM still tested HIV-negative in a few months, he would look for a relationship with a woman who was already HIV-positive. They continued having unprotected sex for 15 months. KM later testified that: (i) she loved Cuerrier and did not want to lose him; (ii) as they had already had unprotected sex, she felt she was probably already infected; (iii) however, she would not have had sex with Cuerrier had she known his HIV status at the outset. At the time of trial, she tested HIV-negative.

A few months later, Cuerrier began a sexual relationship with BH. After their first sexual encounter, she told him she was afraid of diseases, but did not specifically mention HIV. Cuerrier did not tell her he was HIV-positive. No

[7] *Cuerrier*, Case on Appeal, vol 1 at 8(b), 19.

condom was used for about half of their 10 sexual encounters. BH then discovered that Cuerrier was HIV-positive and confronted him, at which point he said he was sorry and should have told her. BH was not infected.

The Proceedings and the Arguments Raised

Cuerrier was charged with two counts of aggravated assault (not *sexual* assault). Section 265 of the *Criminal Code* provides:

> (1) A person commits an assault when ... without the consent of another person, he applies force intentionally to that other person, directly or indirectly.[8]

Section 268 of the *Criminal Code* provides that:

> (1) Every one commits an *aggravated* assault who wounds, maims, disfigures or endangers the life of the complainant.
> (2) Every one who commits an aggravated assault is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.[9]

At trial, the Crown argued that the consent of Cuerrier's two partners was not legally valid because they were unaware of his HIV-positive status. The chief argument was that his non-disclosure constituted "fraud" and that this fraud "vitiated" (ie, rendered legally invalid) his partners' consent to sex. Therefore, the physical sexual contact was an assault. In defining the offence of assault, section 265(3)(c) of the Code states that:

> For the purposes of this section, no consent [to physical contact] is obtained where the complainant submits or does not resist by reason of ... fraud.[10]

The defence successfully moved before the trial judge for a directed verdict of acquittal, on the ground that the Crown had not made out the offence of assault because the complainants had consented to the sexual activity. The Crown appealed to the BC Court of Appeal. The BC Persons with AIDS Society (BCPWA) and the BC Civil Liberties Association (BCCLA) intervened to make submissions against the use of criminal sanctions in this case. The five appellate justices unanimously dismissed the Crown's appeal. The majority noted: "The criminal law of assault is, indeed, an unusual instrument for attempting to ensure safer sex."[11]

The Crown's further appeal to the Supreme Court of Canada was heard in March 1998. The Ontario Attorney General intervened to advance the arguments it had unsuccessfully presented in an earlier, similar case in Ontario.[12] The BCCLA intervened again, and the BCPWA, the Canadian AIDS Society (CAS), and the Canadian HIV/AIDS Legal Network (Network) filed a joint intervention. Arguing against the use of the assault provisions of the *Criminal Code* to criminalize non-disclosure of HIV-positive status, these interveners argued that such a response would likely do little good and might do considerable harm to other efforts to prevent HIV transmission.

[8] RSC 1985, c C-46, s 265(1).

[9] Ibid, s 268.

[10] Ibid, s 265(3)(c).

[11] (1996), 111 CCC (3d) 261 at 282 (per Prowse JA).

[12] *R* v *Ssenyonga* (1993), 81 CCC (3d) 257 (Ont Ct Gen Div).

Ruling on the legal question before it (and not the actual merits of the case), the Supreme Court decided that the accused could be tried on the original two charges of aggravated assault and ordered a new trial. In a media statement released on 28 May, 1999, the BC Attorney General however announced that it would not be proceeding with a new trial against Cuerrier: "Given the unique circumstances of this case, including the reluctance of the complainants to go through another trial, the fact they have not contracted HIV, the amount of time Mr. Cuerrier has already spent in custody on these charges, and the fact he appears to no longer be a public risk as he has stabilized his personal life, the Crown has decided not to re-try the case against him."

The Judgment

The Supreme Court's decision focuses solely on the question of whether an HIV-positive person's non-disclosure of their status can be considered "fraud" for the purposes of the criminal law of assault. Seven (of nine) justices on the Supreme Court heard the case. All concluded that Cuerrier's non-disclosure of his HIV-positive status could constitute fraud.

But they were divided as to how the law should define fraud that vitiates consent to sex. For over a century, courts in Canada, Australia, and the UK had accepted the rule that fraud would make a person's consent to sex legally invalid ("vitiated") only where the fraud related to the "nature and quality of the act." This was also reflected in Canada's *Criminal Code* until amendments to the Code in 1983 eliminated the crimes of "rape" and "indecent assault," and instead defined a single offence of "sexual assault."

The Court unanimously agreed that fraud as to the "nature and quality of the act" could still be considered to vitiate consent. However, they also decided this rule was inadequate and that the operative definition of "fraud" should be extended to cover the situation in the *Cuerrier* case. The justices adopted three different approaches.

Majority decision: a harm-based approach

The majority of the Court (Cory, Major, Bastarache, and Binnie JJ) have set out a new, harm-based approach for deciding what will constitute fraud that vitiates consent to physical contact (including sex). The prosecution must prove the following to establish fraud on the part of the accused person will render their partner's consent legally invalid:

- an act by the accused that a reasonable person would see as dishonest;
- a harm, or a risk of harm, to the complainant as a result of that dishonesty; and
- the complainant would not have consented but for the dishonesty by the accused.

The Court then considered how these might be applied in the context of non-disclosure of HIV-positive status before sexual activity.

Not disclosing HIV-positive status may be "dishonest"

The Court concluded that dishonesty does not mean just "deliberate deceit" about something, but can also include "non-disclosure" of information

> in circumstances where it would be viewed by the reasonable person as dishonest.... This ... can include the non-disclosure of important facts.... The deadly consequences that non-disclosure of the risk of HIV infection can have on an unknowing victim, make it imperative that as a policy the broader view of fraud vitiating consent ... should be adopted. Neither can it be forgotten that the *Criminal Code* has been evolving to reflect society's attitude towards the true nature of the consent.... *In my view, it should now be taken that for the accused to conceal or fail to disclose that he is HIV-positive can constitute fraud which may vitiate consent to sexual intercourse....* It would be pointless to speculate whether consent would more readily follow deliberate falsehoods than failure to disclose. The possible consequence of engaging in unprotected intercourse with an HIV-positive partner is death. *In these circumstances there can be no basis for distinguishing between lies and a deliberate failure to disclose.*[13] [emphasis added]

In my view, it should now be taken that for the accused to conceal or fail to disclose that he is HIV-positive can constitute fraud which may vitiate consent to sexual intercourse.... In these circumstances there can be no basis for distinguishing between lies and a deliberate failure to disclose.

As non-disclosure of HIV-positive status *can* legally be considered "dishonesty" that amounts to fraud, it can vitiate consent to sex:

> Without disclosure of HIV status there cannot be a true consent. The consent cannot simply be to have sexual intercourse. Rather it must be consent to have intercourse with a partner who is HIV-positive. True consent cannot be given if there has not been a disclosure by the accused of his HIV-positive status. A consent that is not based upon knowledge of the significant relevant factors is not a valid consent.[14]

True consent cannot be given if there has not been a disclosure by the accused of his HIV-positive status.

Having decided that non-disclosure (and not just deliberate deceit) can amount to "dishonesty," the Court then turned to the question of *when* the duty to disclose exists. Not disclosing HIV-positive status cannot be objectively considered "dishonest" unless there is a duty to disclose.

When disclosure is required

As noted above, the traditional rule was that the only kind of fraud that would render consent to an act of physical contact legally invalid was fraud as to the identity of the person doing the act or fraud as to the "nature and quality of the act" (ie, was it a sexual act, or something else). For example, the Ontario Court of Appeal had ruled that there was fraud vitiating consent where a man falsely held himself out to be a doctor and purported to conduct gynecological examinations of several women; the women consented to a medical examination, but received something different.[15] On this rule, the consent of a person to engage in sexual activity was not rendered invalid by their partner's fraud, as long as the fraud did not alter the basic nature of the act as sexual.

However, the Court rejected that rule as too narrow, and so struggled to create a new rule for defining the circumstances in which dishonesty will be considered fraud in the criminal law. In answering the question of when there is a duty to disclose, the Court considered the second requirement of fraud that it has identified: "that the dishonesty result in deprivation, which may consist of actual harm or simply a risk of harm."[16]

[13] *Cuerrier*, supra, note 1 at 47, 49, citing *R* v *Olan*, [1978] 2 SCR 1175; *R* v *Théroux*, [1993] 2 SCR 5; *R* v *Zlatic*, [1993] 2 SCR 29.

[14] Ibid at 50.

[15] *R* v *Maurantonio*, [1968] 1 OR 145, 65 DLR (2d) 674 (CA).

[16] Ibid.

The Crown will have to establish that the dishonest act (either falsehoods or failure to disclose) had the effect of exposing the person

The nature and extent of the duty to disclose, if any, will always have to be considered in the context of the particular facts presented.

Absolutely safe sex may be impossible. *Yet the careful use of condoms might be found to so reduce the risk of harm that it could no longer be considered significant.*

The Court thus sets out a new approach to defining fraud in the context of criminal assault, based on "risk of harm." However, the Court immediately cautions against an overly broad approach:

> Yet it cannot be any trivial harm or risk of harm that will satisfy this requirement in sexual assault cases where the activity would have been consensual if the consent had not been obtained by fraud. For example, the risk of minor scratches or of catching cold would not suffice to establish deprivation [harm]. What then should be required? In my view, the Crown will have to establish that the dishonest act (either falsehoods or failure to disclose) had the effect of exposing the person consenting to *a significant risk of serious bodily harm*. The risk of contracting AIDS as a result of engaging in unprotected intercourse would clearly meet that test. In this case the complainants were exposed to a significant risk of serious harm to their health. Indeed their very survival was placed in jeopardy. It is difficult to imagine a more significant risk or a more grievous bodily harm.[17] [emphasis added]

The phrase "significant risk of serious bodily harm" is the crux of the decision. Yet the vagueness of this test raises further questions for HIV-positive people,[18] while also suggesting possible limitations on the application of this precedent in future cases. The Court has indicated there may be circumstances in which the risk of harm is not great enough to require disclosure:

> The extent of the duty to disclose will increase with the risks attendant upon the act of intercourse. To put it in the context of fraud, the greater the risk of deprivation the higher the duty of disclosure. The failure to disclose HIV-positive status can lead to a devastating illness with fatal consequences. In those circumstances, there exists a positive duty to disclose. The nature and extent of the duty to disclose, if any, will always have to be considered in the context of the particular facts presented.[19]

> To have intercourse with a person who is HIV-positive will always present risks. Absolutely safe sex may be impossible. *Yet the careful use of condoms might be found to so reduce the risk of harm that it could no longer be considered significant so that there might not be either deprivation or risk of deprivation* [ie, harm or risk of harm]. To repeat, in circumstances such as those presented in this case, there must be a significant risk of serious bodily harm before the section can be satisfied. In the absence of those criteria, the duty to disclose will not arise."[20] [emphasis added]

The judgment is clear that this standard is also "sufficient to encompass not only the risk of HIV infection but also other sexually transmitted diseases which constitute a significant risk of serious harm."[21]

Causal connection between non-disclosure and partner's consent

Finally, in order to secure a conviction for assault, the prosecution must prove a third element: the causal connection between the HIV-positive person's

[17] Ibid.

[18] See: Criminal Law and HIV/AIDS Info Sheet 7: The *Cuerrier* Case: Issues for People with HIV/AIDS. Montréal: Canadian HIV/AIDS Legal Network, 1999.

[19] *Cuerrier*, supra, note 1 at 50-51.

[20] Ibid.

[21] Ibid at 53.

non-disclosure and their partner's consent to sex. As Cory J writes for the majority:

> In situations such as that presented in this case, it must be emphasized that the Crown will still be required to prove beyond a reasonable doubt that the complainant would have refused to engage in unprotected sex with the accused if she had been advised that he was HIV-positive. As unlikely as that may appear, it remains a real possibility. In the words of other decisions it remains a live issue.[22]

Minority judgments

As noted above, the traditional rule was that fraud as to the "nature and quality of the act" would vitiate consent to sex. Writing for herself and Gonthier J, McLachlin J concluded this rule should simply be expanded by adding another category of fraud that will vitiate consent: "the common law should be changed to permit deceit about sexually transmitted disease that induces consent to be treated as fraud vitiating consent under s. 265 of the *Criminal Code*."[23] McLachlin J reflects a sentiment shared by the entire Court when she states:

> In the case at bar, I am satisfied that the current state of the law does not reflect the values of Canadian society. It is unrealistic, indeed shocking, to think that consent given to sex on the basis that one's partner is HIV-free stands unaffected by blatant deception on that matter. To put it another way, few would think the law should condone a person who has been asked whether he has HIV, lying about that fact in order to obtain consent. To say that such a person commits fraud vitiating consent, thereby rendering the contact an assault, seems right and logical.[24]

In McLachlin J's view, expanding the definition of fraud in this way is consistent with the long-standing rule that fraud as to the "nature and quality of the act" will vitiate consent:

> Where the person represents that he or she is disease-free, and consent is given on that basis, deception on that matter goes to the very act of assault. The complainant does not consent to the transmission of diseased fluid into his or her body. This deception in a very real sense goes to the nature of the sexual act, changing it from an act that has certain natural consequences (whether pleasure, pain or pregnancy), to a potential sentence of disease or death. It differs fundamentally from deception as to the consideration that will be given for consent, like marriage, money or a fur coat, in that it relates to the physical act itself. It differs, moreover, in a profoundly serious way that merits the criminal sanction. This suffices to justify the position ... that deception as to venereal disease may vitiate consent.[25]

In her own minority judgment, L'Heureux-Dubé J proposed to go much further. In her view, whether the fraud in question carried a harm or risk of harm is irrelevant. If the accused acted in a way that can objectively be described as

[22] Ibid at 51.

[23] Ibid at 37.

[24] Ibid at 33.

[25] Ibid at 35-36.

dishonest, and this induces their partner to consent to contact, then there is no legally valid consent. According to L'Heureux-Dubé J, for the purposes of the crime of assault:

> fraud is simply about whether the dishonest act in question induced another to consent to the ensuing physical act, whether or not that act was particularly risky and dangerous. The focus of the inquiry into whether fraud vitiated consent so as to make certain physical contact non-consensual should be on whether the nature and execution of the deceit deprived the complainant of the ability to exercise his or her will in relation to his or her physical integrity with respect to the activity in question.... Where fraud is in issue, the Crown would be required to prove beyond a reasonable doubt that the accused acted dishonestly in a manner designed to induce the complainant to submit to a specific activity, and that absent the dishonesty, the complainant would not have submitted to the particular activity, thus considering the impugned act to be a non-consensual application of force.... The dishonesty of the submission-inducing act would be assessed based on the objective standard of the reasonable person. The Crown also would be required to prove that the accused knew, or was aware, that his or her dishonest actions would induce the complainant to submit to the particular activity.[26]

These two minority approaches are (perhaps) simpler to define and apply than the "significant risk of harm" approach adopted by the majority. However, the incrementalist approach proposed by McLachlin J offers no principled reason for singling out HIV/STDs as an additional category of fraud that vitiates consent – as opposed to any other sort of fraud that might lead a person to consent to sex. And as all the other justices are at pains to point out, the approach proposed by L'Heureux-Dubé J "vastly extends the offence of assault"[27] and "would trivialize the criminal process by leading to a proliferation of petty prosecutions instituted without judicial guidelines or directions."[28] As McLachlin J succinctly puts it in her critique of L'Heureux-Dubé J's position: "what constitutes deception is by its very nature highly subjective. One person's blandishment is another person's deceit, and on this theory, crime."[29]

[26] Ibid at 16-17.

[27] Ibid at 28 (per McLachlin J).

[28] Ibid at 51 (per Cory J).

[29] Ibid at 28-29.

Disclosure of Serostatus by People with HIV/AIDS

On its facts, the *Cuerrier* decision applies only to cases of HIV exposure through unprotected sexual activity. However, the purpose of this Paper is to consider not only what it means for sexual activity by HIV-positive people, but also what it may mean – and should not mean – regarding criminal liability for conduct outside the realm of sexual activity that risks transmitting HIV. In this chapter the Paper considers the significance of *Cuerrier* with respect to criminal prosecution for HIV exposure in the following four contexts:

- sexual activity;
- sharing drug injection equipment;
- mother–infant transmission; and
- transmission via invasive medical procedures

Sexual Activity

Given the facts of *Cuerrier*, its significance is obviously greatest for HIV-positive people in the conduct of their sexual lives. However, the decision raises several questions as to its possible interpretation and application in this context. The Paper attempts to answer some of these questions as well as possible, given the ambiguities in the decision.

"Significant risk" and a "safer sex" defence

As noted above, the Supreme Court ruled that an HIV-positive person *may* be prosecuted for the crime of assault if they engage in unprotected sex without

The most obvious, unanswered question raised by the *Cuerrier* decision is: what constitutes a legally "significant" risk of HIV transmission?

disclosing their serostatus. The Court ruled that it would be "dishonest" to not disclose this fact if the sexual activity presented a "significant risk of serious bodily harm."[30] As a result, their partner's consent to sex can be said to have been obtained by "fraud." This means their consent is not legally valid and the physical contact is an "assault." The most obvious, unanswered question raised by the *Cuerrier* decision is: what constitutes a legally "significant" risk of HIV transmission?

The Court's judgment in *Cuerrier* indicates that, in Canadian criminal law, unprotected vaginal intercourse (and therefore presumably anal intercourse) will be considered to carry a (legally) "significant" risk of HIV infection. This means there is an obligation to disclose HIV-positive status before engaging in this activity. The Court stated that "in the case at bar, the failure to disclose the presence of HIV put the victims at a significant risk of serious bodily harm."[31]

It is also worth noting that a similar standard was articulated by the US Presidential Commission on HIV. While the Commission's 1988 report led several US states to enact criminal legislation relating to HIV transmission or exposure, the Commission itself cautioned that the law should be carefully applied to only address conduct that poses a "significant risk of transmission" and should "be directed only toward behaviors scientifically established as a mode of transmission."[32]

Unfortunately, there are several examples of US legislation and judicial decisions that have failed to heed this sensible restriction, extending criminal liability to conduct such as biting or spitting, when data available after two documented decades of the HIV epidemic indicate a statistically infinitesimal risk of HIV transmission through such conduct.[33] Misuse of the aggravated-assault provisions against HIV-positive people for biting have also been seen in Canada, although to a lesser extent.[34] By articulating the standard of "significant risk," the *Cuerrier* case should at least signal to police, prosecutors, and lower courts that this is an abuse and misapplication of *aggravated* assault or other more serious charges.

Legal standard should follow accepted risk-assessment guidelines

Legal assessments of "risk" in this area should be consistent with available epidemiological conclusions regarding the risks of transmission associated with various sexual activities. This epidemiological data itself provides the basis of current, widely accepted guidelines for assessing the risks of HIV transmission and for counseling practices and public education regarding preventing and reducing the risk of HIV infection. In Canada,

> the levels of risk of various activities are organized into four categories, based on the potential for transmission of HIV and the documented evidence that transmission has actually occurred. These categories of HIV transmission are: no risk; negligible risk; low risk; high risk.... If these categories or levels were represented graphically on a continuous line, negligible and low risk would be much closer to the no risk end of the continuum. There is no "middle" level of risk.[35]

With respect to sexual activity, these widely accepted guidelines for risk assessment identify only "insertive or receptive penile–anal or penile–vaginal

[30] The Supreme Court has ruled that "serious bodily harm" may include serious psychological harm if it "substantially interferes" with health or well-being: *R* v *McCraw*, [1991] 3 SCR 72 at 81; *John Smith* v *James Jones*, [1999] SCJ No 15 (QL) at para 83.

[31] *Cuerrier*, supra, note 1 at 51.

[32] *Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic.* Washington: US Government Printing Office, 1988, at 130.

[33] CM Tsoukas et al. Lack of transmission of HIV through human bites and scratches. *Journal of AIDS* 1988; 1: 505-507; KM Richman, LS Riskman. The potential for transmission of human immunodeficiency virus through human bites. *Journal of AIDS* 1993; 6(4): 402-406.

[34] For example, see *R* v *Thissen*, [1998] OJ No 1982 (CA) (QL), aff'g unreported decision of 16 May 1996, Ontario Court (Prov Div), Toronto (Cadsby J), reported at: R Elliott. Justice Delayed and Denied in Biting Case. *Canadian HIV/AIDS Policy & Law Newsletter* 1997/98; 3(4)/4(1): 44.

[35] Canadian AIDS Society. *HIV Transmission: Guidelines for Assessing Risk* (3d ed). Ottawa: Canadian AIDS Society, 1999, at 18.

intercourse without a condom..., [or] receptive insertion of shared 'sex toys'" as representing a "high" risk of transmission. Other activities are either classified as "low risk" (including unprotected oral sex and insertive intercourse with a latex barrier) or "negligible risk" (including oral sex with the use of a latex barrier), or carry "no risk" of HIV transmission.[36]

Although ambiguous and open to further interpretation in some respects, the *Cuerrier* decision does permit or require at least the following conclusions:

- A single act of unprotected vaginal or anal intercourse carries a (legally) "significant" risk of HIV transmission. Not disclosing HIV-positive status before engaging in these activities can result in criminal liability. While *Cuerrier* dealt with a case of vaginal intercourse, "the risk of HIV infection from anal intercourse is even greater than that from vaginal intercourse, due to the increased fragility of the membranes in the rectum and the risk of trauma (cuts, abrasions) in this area."[37]
- It makes no (legal) difference if the HIV-positive partner who engaged in unprotected vaginal or anal intercourse was insertive or receptive. It is true that the *Cuerrier* case was one in which an HIV-positive man exposed female sexual partners to the risk of infection, and available evidence indicates that "women have a greater risk of becoming infected during vaginal intercourse than men due to a higher concentration of HIV in semen than in vaginal fluid, the large surface area of the vagina and cervix, and the fragility of the membranes in these areas."[38] However, it is incorrect to conclude that the judgment applies only to HIV-positive men who have sex with women. The decision applies to any HIV-positive person who engages in conduct that carries a "significant" risk of transmission. All unprotected anal or vaginal intercourse is considered "high" risk for both participants, regardless of the sex of the participants and whether they are insertive or receptive.

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It is unclear whether there would be a duty to disclose HIV-positive status if a person engaged on many occasions in protected anal or vaginal intercourse, or unprotected oral sex, with the same partner. Statistically, the risk of transmission associated with a single instance of these activities is small, and the activity is classified as "low risk." However, over a series of such acts, the cumulative statistical risk of transmission may be more significant.

Recognizing a "safer sex" defence

In *Cuerrier*, the organizations intervening before the Court urged that, if the Court were to impose criminal liability for non-disclosure of HIV-positive status, this should not extend so far as to impose an unqualified duty to always disclose HIV-positive status. The key public health message regarding HIV prevention has always been, and continues to be, the need to assume that all sexual partners may be HIV-positive and, accordingly, to practise "safer sex" with all partners, thereby significantly reducing the risk of HIV transmission. Interveners submitted that any duty imposed by the criminal law should be consistent, rather than at odds, with this public health message. The criminal law should not always demand full disclosure by HIV-positive people of their serostatus.

Rather, instead of disclosure being required in every circumstance, it should be enough to avoid criminal liability if an HIV-positive person takes

[36] Ibid at 21.

[37] *HIV and Sexual Violence Against Women*. Ottawa: Health Canada, 1998, at 9. See also: N Padian et al. Female-to-male transmission of HIV. *Journal of the American Medical Association* 1991; 266: 1664-1667. See also *HIV Transmission: Guidelines for Assessing Risk*, *supra*, note 35 at 26-27.

[38] *HIV and Sexual Violence Against Women*, supra, note 37 at 9. See also: Padian et al, supra note 37; and CAS, *HIV Transmission*, *supra*, note 35, at 26-27.

precautions to reduce the risk of HIV transmission (eg, practising safer sex). Given the stigma and other adverse consequences that may flow from disclosing one's HIV-positive status, taking precautions is (generally speaking) easier than actually disclosing, and achieves the same goal of preventing HIV transmission.

The Supreme Court did not rule definitively on this question. However, the judgment contemplates that this "safer sex" defence may be accepted:

> To have intercourse with a person who is HIV-positive will always present risks. Absolutely safe sex may be impossible. *Yet the careful use of condoms might be found to so reduce the risk of harm that it could no longer be considered significant* so that there might not be either deprivation or risk of deprivation [ie, harm or risk of harm]. To repeat, in circumstances such as those presented in this case, there must be a significant risk of serious bodily harm before the [assault] section can be satisfied. In the absence of those criteria, the duty to disclose will not arise.[39]

It seems logical and likely that, *if* condom use were accepted as lowering the risk enough that it is no longer legally "significant," then the same treatment would and should be afforded to other "safer sex" practices that lower the risk to the level of "low" risk or below.

According to current risk-assessment guidelines, the use of condoms for vaginal or anal intercourse lowers the risk of that activity from "high" to "low."[40] This statement should be considered a direction to lower courts and to prosecutors that an HIV-positive person is not subject to criminal liability for not disclosing their status as long as they do not engage in "high risk" activity. While condom use is only one method of reducing the risk of transmission, it is the only one explicitly referred to in the Court's judgment in *Cuerrier*. However, it seems logical and likely that, *if* condom use were accepted as lowering the risk enough that it is no longer legally "significant," then the same treatment would and should be afforded to other "safer sex" practices that lower the risk to the level of "low" risk or below.

It remains to be seen whether this approach will be adopted by the courts. In *Thornton*, a case of an HIV-positive man charged with the crime of *common nuisance* for donating blood, the Ontario Court of Appeal was considering whether the charge could be legally sustained. A person commits a *common nuisance* (*Criminal Code*, s 180) where they do something unlawful, or fail to do something they have a legal duty to do, thereby endangering the lives, safety, or health of the public or causing physical injury to someone. In light of the likelihood that his blood would have been detected through screening, the accused argued that his conduct did not endanger the health of the public. The Court ruled that "where the gravity of the potential harm is great, in this case 'catastrophic,' the public is endangered even where the risk of harm actually occurring is slight, indeed even if it is minimal."[41]

However, the *Thornton* case arose in a significantly different factual context and with respect to a different criminal charge. It has also been the subject of criticism as being overly broad and in conflict with other provisions in the *Criminal Code* (s 8) restricting such a loose interpretation.[42] *Thornton* should not necessarily be adopted as a standard for the interpretation of assault charges for non-disclosure of HIV status.

Furthermore, the *Cuerrier* decision itself – dealing directly with the issue of non-disclosure of HIV-positive status in the context of sexual activity – indicates a narrower approach is warranted in defining what constitutes a

[39] *Cuerrier*, supra, note 1 at 50-51.

[40] *HIV Transmission: Guidelines for Assessing Risk*, supra, note 35 at 20-21, 27.

[41] *R* v *Thornton* (1991), 1 OR (3d) 480 at 488, aff'd [1993] 2 SCR 445, 82 CCC (3d) 530, 21 CR (4th) 215.

[42] WH Holland. HIV/AIDS and the criminal law. *Criminal Law Quarterly* 1994; 36(3): 279-316; Elliott, supra, note 2 at 87-88.

"significant" risk. As noted above, Cory J for the majority suggested that careful condom use might sufficiently lower the risk that disclosure is not required. Elsewhere in the majority judgment, he also cautions against "trivializing" the criminal process, emphasizing that "it cannot be any trivial harm or risk of harm that will satisfy" the requirement of a risk of harm for imposing criminal liability:

> The existence of fraud should not vitiate consent unless there is a significant risk of serious harm. Fraud which leads to consent to a sexual act but which does not have that significant risk might ground a civil action. However, it should not provide the foundation for a conviction for sexual assault.… The phrase "significant risk of serious harm" must be applied to the facts of each case in order to determine if the consent given in the particular circumstances was vitiated. Obviously consent can and should, in appropriate circumstances, be vitiated. Yet this should not be too readily undertaken. The phrase should be interpreted in light of the gravity of the consequences of a conviction for sexual assault and with the aim of avoiding the trivialization of the offence. It is difficult to draw clear bright lines in defining human relations particularly those of a consenting sexual nature. There must be some flexibility in the application of a test to determine if the consent to sexual acts should be vitiated. The proposed test may be helpful to courts in achieving a proper balance when considering whether on the facts presented, the consent given to the sexual act should be vitiated.[43]

In the result, six of the seven justices who heard the *Cuerrier* case have suggested that the person who does not disclose their HIV-positive status but who practises safer sex should not be subject to criminal prosecution for non-disclosure.

While in the minority, McLachlin J's judgment (for herself and Gonthier J) in *Cuerrier* also supports the conclusion that disclosure should not be required if safer sex is practised. While taking the position that non-disclosure of HIV/STDs should be considered a fraud that vitiates consent to sex, she also adds that her approach would only expand the scope of criminal liability to a limited extent:

> Again, protected sex would not be caught; the common law pre-*Clarence* required that there be a high risk or probability of transmitting the disease: *Sinclair*, *supra*. These observations largely displace the fear of unprincipled overextension [of the criminal law of assault] that motivated the majority in *Clarence* to exclude deceit as to sexually transmitted disease a basis on which fraud could vitiate consent.[44]

In the result, six of the seven justices who heard the *Cuerrier* case have suggested that the person who does not disclose their HIV-positive status but who practises safer sex should not be subject to criminal prosecution for non-disclosure.

The UN Guidelines on HIV/AIDS and Human Rights specifically address the issue of criminal laws, advising states to ensure that, if criminal offences are applied to conduct that transmits or risks transmitting HIV, then "such application should ensure that the elements of foreseeability, intent, causality and consent are clearly and legally established to support a guilty verdict and/or harsher penalties." [45] Interpreting *Cuerrier* so as to confirm the

[43] *Cuerrier*, supra, note 1 at 52-54.

[44] Ibid at 36, citing *R* v *Clarence* (1888), 22 QBD 23 and *R* v *Sinclair* (1867), 13 Cox CC 28.

[45] UN High Commissioner/Centre for Human Rights and Joint UN Programme on HIV/AIDS (UNAIDS). Guidelines on HIV/AIDS and Human Rights. New York and Geneva: United Nations, 1998 (HR/PUB/98/1).

safer-sex defence suggested by a majority of the Supreme Court would provide a clear(er) definition for Canadians of that conduct which is prohibited by the criminal law and that which is permitted. As McLachlin J emphasized in her judgment: "the criminal law must be clear... [I]t is imperative that there be a clear line between criminal and non-criminal conduct. Absent this, the criminal law loses its deterrent effect and becomes unjust."[46]

Finally, an interpretation of *Cuerrier* that recognizes a "safer sex" defence would be consistent with the principle of restraint in the use of the criminal law that has been generally accepted and approved in Canada, including by the federal government. As stated in *The Criminal Law in Canadian Society*:

> As the most serious form of social intervention with individual freedoms, the criminal law is to be invoked only where necessary, when the use of other means is clearly inadequate or would depreciate the seriousness of the conduct in question. As well, the principle suggests that, even after the initial decision has been made to invoke the criminal law, the nature or extent of the response by the criminal justice system should be governed by considerations of economy, necessity and restraint, consonant of course with the need to maintain social order and protect the public.[47]

The only sure way to avoid criminal liability for engaging in sexual activity that carries a risk ("high" or "low") is to disclose HIV-positive status.

Recognizing a "safer sex" defence would also be consistent with existing guidelines for assessing HIV transmission risks and with the standard advice disseminated to the public as to the riskiness of various sexual practices and the need to reduce risks by practising safer sex. This would, to the greatest extent possible, align the decision in *Cuerrier* with existing public health education and prevention efforts. Such a recommendation was put forward by the Legal Working Group of the Intergovernmental Committee on AIDS in Australia, in its submissions regarding the draft Model Criminal Code being prepared for adoption in all Australian jurisdictions.[48] This recommendation was also made in Canada in *Criminal Law and HIV/AIDS: Final Report*:

> To criminalize the HIV-positive person who, although s/he does not disclose, actually practises safer sex or otherwise seeks to reduce the risk to his/her partner(s), would be directly counterproductive to the very goal of preventing further transmission.... Criminalizing safer sex would be a perverse use of the criminal law, and directly in conflict with a sound public health policy.[49]

It is important that this aspect of the decision be properly understood by HIV-positive people and others. As the law currently remains uncertain, it would be premature to simply advise HIV-positive people that they need not disclose their status as long as condoms are used for vaginal or anal intercourse. People with HIV/AIDS need to be clearly informed that the law is not yet clear on this point. The only sure way to avoid criminal liability for engaging in sexual activity that carries a risk ("high" or "low") is to disclose HIV-positive status.

[46] *Cuerrier*, supra, note 1 at 34 (per McLachlin J).

[47] Government of Canada. *The Criminal Law in Canadian Society*. Ottawa, 1982.

[48] Intergovernmental Committee on AIDS. *Final Report of the Legal Working Party of the Intergovernmental Committee on AIDS*. Canberra: Department of Health, Housing and Community Services, 1992, at 21.

[49] Elliott, supra, note 2 at 91-92.

Recommendations

Recommendation 1

> *Courts should only consider "high risk" activities, as defined in current risk-assessment guidelines, as posing a legally "significant" risk of HIV transmission for the purposes of the criminal law. Those activities that carry only a "low" or "negligible" risk should not be considered "significantly" risky in a legal sense and should therefore not sustain a criminal prosecution for non-disclosure of HIV-positive status. This should be clarified by the courts in their interpretation of* Cuerrier**.**

Recommendation 2

> *In interpreting* Cuerrier *as applying only to non-disclosure before engaging in "high risk" activity, courts should expressly recognize a "safer sex" defence, meaning that HIV-positive people who use condoms for penetrative sex or who otherwise modify their conduct so as to avoid "high risk" activities are not criminally liable if they do not disclose their serostatus.*

Recommendation 3

> *Police and prosecutors should refrain from criminal prosecutions in the absence of evidence of "high risk" conduct without disclosure by an HIV-positive person. Attorneys General should direct Crown attorneys accordingly.*

Recommendation 4

> *Educational materials and information for people with HIV/AIDS needs to be clear that engaging in "high risk" activity (eg, unprotected vaginal or anal intercourse) without disclosing serostatus could result in criminal liability. Such education must also convey that presently the criminal law is not clear as to whether it requires disclosure of HIV-positive status before engaging in "low risk" activities (such as unprotected oral sex, or vaginal or anal intercourse with the use of a condom). In all likelihood, disclosure is not required before engaging in "negligible risk" activities. "No risk" activities do not require disclosure.*

Putting the "dishonesty" of non-disclosure in context

As noted above, the Court ruled that the actions of the accused HIV-positive person must be "assessed objectively to determine whether a reasonable person would find them to be dishonest."[50] If there is a duty to disclose HIV-positive status – because the sexual activity carries a "significant" risk of transmission – then it is dishonest to not disclose this fact. But the *Cuerrier* case also indicates that disclosure is not always required. This means an HIV-positive person is not always dishonest if they do not disclose their HIV-positive status. According to the Court,

> [t]he extent of the duty to disclose will increase with the risks attendant upon the act of intercourse.... The nature and extent of the duty to disclose, if any, will always have to be considered in the context

[50] *Cuerrier*, supra, note 1 at 49.

> of the particular facts presented.... In the absence of [a significant risk of serious bodily harm], the duty to disclose will not arise.[51]

Assessing competing risks of harm

People with HIV/AIDS need to be aware that there is no clear indication in the law, as it currently stands, as to whether some circumstances may mean that disclosure is not required.

As one participant at the national workshop observed, "dishonesty" is a "loaded" term that makes it difficult to acknowledge the difficulties of disclosing and to discuss the complexity of the issue.[52] Courts have recognized that a *contextual approach* to the application of legal duties and sanctions is required in the interests of avoiding injustice, and is it urged here that this be heeded in future interpretation and application of *Cuerrier*.

The Supreme Court has indicated in *Cuerrier* that there is no duty to disclose unless there is a "significant" risk of transmission. However, might there also be circumstances in which an HIV-positive person will not be required to disclose their serostatus to a sexual partner, even though they are engaged in an activity where there *is* a significant risk of transmitting HIV? The Court does not address this question, and therefore no definitive answer can be given. People with HIV/AIDS need to be aware that there is no clear indication in the law, as it currently stands, as to whether some circumstances may mean that disclosure is not required.

However, this question may be of particular concern to HIV-positive people who may find themselves in situations where disclosure of their serostatus is not simply difficult but also dangerous; this would include prostitutes, prisoners, and women (or others) in abusive relationships. The HIV-positive person may be concerned that disclosing their status will prompt physical violence from a sexual partner.[53] As noted by a Health Canada report on the link between HIV and violence against women:

> Women living with HIV face some unique challenges connected to HIV and sexual violence, particularly those who are in an abusive relationship. Disclosure of a woman's HIV status to her partner can increase her susceptibility to sexual and physical violence. Knowledge of her HIV status can give her abuser further control in the relationship. For example, her abuser may use her HIV status against her by threatening to tell others. HIV-positive women may stay in abusive relationships because of decreased self-worth and because they believe that no other person would want to have a relationship with them.… Women living with HIV also face the fear and threat of rejection or emotional, physical and/or sexual violence from friends, family members, co-workers and their community. Incarcerated women and women from ethnocultural and Aboriginal communities may confront increased risk of stigmatization and violence as a result of disclosure of their HIV status.[54]

A 1995 US study surveying 136 health-care providers reinforces these concerns about the risks of disclosure that HIV-positive women in particular may face.[55] The study found that:

- 24 percent of providers reported having female patients who were victims of physical violence after telling their partner they were HIV-positive;

[51] Ibid at 50-51.

[52] For a detailed discussion of discrimination and stigma still experienced by people with HIV/AIDS in Canada, see T de Bruyn. *HIV/AIDS and Discrimination: A Discussion Paper*. Montréal: Canadian HIV/AIDS Legal Network & Canadian AIDS Society, 1998.

[53] A Gielen et al. Women and HIV: disclosure concerns and experiences. Women and HIV Conference, Washington DC, 1995; VB Brown et al. Mandatory partner notification of HIV test results: psychological and social issues for women. *AIDS & Public Policy Journal* 1994; 9(2): 86-92.

[54] *HIV and Sexual Violence Against Women*, supra, note 37 at 7.

[55] KH Rothenberg et al. Domestic violence and partner notification: implications for treatment and counseling of women with HIV. *Journal of the American Medical Women's Association* 1995; 50: 87-93 at 89. See also: RL North, KH Rothenberg. Partner notification and the threat of domestic violence against women with HIV infection. *New England Journal of Medicine* 1993; 329: 1194-1196; and K Rothenberg, S Paskey. The risk of domestic violence and women with HIV infection: implications for partner notification, public policy, and the law. *American Journal of Public Health* 1995; 85: 1569-1576.

- 38 percent of providers reported having at least one female patient who experienced "emotional abuse" (including threats of violence or intimidation) following disclosure to a partner;
- 37 percent of providers reported having at least one female patient who experienced "abandonment" (defined as withdrawal of financial support, shelter, or access to family members or belongings) following disclosure;
- to the knowledge of these health-care providers, 8 percent of the female patients of these providers experienced physical violence soon after disclosure to partners, 23 percent experienced emotional abuse, and 19 percent experienced abandonment;
- nearly half (45 percent) of all providers had at least one female patient who expressed fear of physical violence resulting from disclosure of her HIV diagnosis to a partner, while 56 percent of providers encountered patients who expressed fear of emotional abuse, and 66 percent reported having patients who expressed fear of abandonment;
- among providers who encountered these fears in female patients, 18 percent of their patients expressed fear of physical violence following disclosure, while 29 percent expressed fear of emotional abuse, and 35 percent expressed fear of abandonment;
- 55 percent of all providers surveyed had at least one female patient who resisted disclosure of her HIV status to a partner during the previous year, and an average of 26 percent of the female patients of these providers resisted disclosing to a partner;
- 63 percent of providers had at least one female patient who reported living in a situation involving violence or emotional abuse;
- among those providers who reported having at least one female patient whose living situation was unknown to them, the providers were unaware of the living situation of almost half (45 percent) of their female patients; and
- 80 of the providers opposed disclosing their patient's HIV-positive status to the patient's partner where the patient did not consent and there was a "strong likelihood" of physical violence; even when violence or emotional abuse was not deemed to be likely, nearly half (45 percent) of providers opposed disclosure in the absence of patient consent.

The authors of the study note:

> The possibility of abuse against HIV-infected women underscores the importance of assessment and intervention as a preventive measure. The consequences of failing to assess and intervene are clear: abuse is likely to continue and in many cases may escalate.... [I]t is reasonable to assume that the problem of domestic violence is at least as severe among HIV-infected women as it is among women in general. Indeed, the need for assessment and intervention may be greatest among those populations of women most likely to be diagnosed with AIDS or HIV infection. The women at highest risk of infection – those who use intravenous drugs – may also face an increased risk of domestic violence.[56]

It will often be the case that someone who risks violence or abuse upon disclosure of their HIV-status is also limited in their ability to ensure that precautions

[56] Rothenberg et al, supra, note 55 at 92.

such as the use of condoms or other "safer sex" practices are taken to reduce the risk of transmission to a sexual partner. In such circumstances, would the "reasonable person" consider it "dishonest" for an HIV-positive person to not disclose their status?

What if the HIV-positive person indicates they wish to practise safer sex, but the other participant refuses and there is a risk of violence if the HIV-positive person persists with the request? An obvious example would be that of a sex worker with HIV/AIDS whose client refuses to use condoms and who might become violent if the matter is pushed too far. What if a person goes so far as to indicate the possibility that they may be HIV-positive – thereby putting the other participant "on notice" – but stops short of actual disclosure? Is the person "dishonest" if they do not disclose under such circumstances? The *Cuerrier* decision offers no clear or easy answers to these questions, and people with HIV/AIDS should not be left with the impression that these issues are settled.

In a recent report opposing coercive approaches to partner notification, the American Civil Liberties Union has noted the evidence indicating that people fear disclosure of their HIV status to partners:

> Many of those who are resistant to partner notification struggle with substantial fears of discrimination, debilitating social and economic instability, and violence. Their decisions about whether to reveal deeply personal and sometimes embarrassing information about their lives and contacts are often made in the face of limited emotional and economic resources and a daily struggle for survival. The addition of coercive state intervention can be crushing.... [C]oercive partner notification can be physically dangerous.... Other populations [besides women fearing violence] also deeply fear involuntary partner notification. Among clients of a methadone detoxification program, one study found that 59% of the HIV positive clients said they would not enter treatment if HIV testing and partner notification were required. Another analysis of drug users' views about partner notification found that at least 50% of those surveyed identified their distrust of government agencies as a barrier to their participation in partner notification. High levels of resistance to partner notification have also been documented among gay and bisexual men.[57]

In *Cuerrier*, both the majority and minority justices expressed the view that imposing criminal sanctions would have some effect in deterring unprotected sex without disclosure of HIV-positive status, and would thus assist in protecting those who would otherwise be placed at risk. The Court dismissed concerns raised by the interveners that criminally punishing people for not disclosing their HIV-positive status

- would be unlikely to have any significant deterrent effect on unsafe sex without disclosure and would therefore be of little protective benefit to those at risk of infection;
- does not address the underlying reasons why people (women, sex workers, and prisoners in particular) may find themselves with little or limited ability to ensure that safer-sex precautions are taken; and

[57] American Civil Liberties Union. *HIV Partner Notification: Why Coercion Won't Work*. New York: ACLU, March 1998. See following research studies cited therein: SM Rubin. Partner Notification May Deter HIV Positive Drug Users from Treatment, VII International Conference on AIDS, 1991, Abstract #WD1; S Rogers. Partner Notification with HIV-Infected Drug Users: Results of Formative Research, XI International Conference on AIDS, 1996, Abstract #Th.C.4629; and SE Landis et al. Results of a randomized trial of partner notification in cases of HIV infection in North Carolina. *New England Journal of Medicine* 1992; 326: 101.

- compounds the already significant difficulties of disclosing HIV-positive status.

Unfortunately, the *Cuerrier* judgment does not provide much, if any, consideration of how a "duty to disclose" may actually be experienced by people living with HIV/AIDS. The Court does not address the competing factors that may weigh against imposing a duty to disclose in some circumstances. Instead, in dismissing these concerns, the majority took the view that the criminal law

> provides a needed measure of protection in the form of deterrence and reflects society's abhorrence of the self-centered recklessness and the callous insensitivity of the actions of the respondent and those who have acted in a similar manner..... If ever there was a place for the deterrence provided by criminal sanctions it is present in these circumstances. It may well have the desired effect of ensuring that there is disclosure of the risk and that appropriate precautions are taken....
>
> It is true that all members of society should be aware of the danger and take steps to avoid the risk. However, the primary responsibility for making the disclosure must rest upon those who are aware they are infected. I would hope that every member of society no matter how "marginalized" would be sufficiently responsible that they would advise their partner of risks. In these circumstances it is, I trust, not too much to expect that the infected person would advise his partner of his infection. That responsibility cannot be lightly shifted to unknowing members of society who are wooed, pursued and encouraged by infected individuals to become their sexual partners.[58]

The *Cuerrier* judgment does not provide much, if any, consideration of how a "duty to disclose" may actually be experienced by people living with HIV/AIDS. The Court does not address the competing factors that may weigh against imposing a duty to disclose in some circumstances.

It remains to be seen whether courts will recognize that disclosing HIV-positive status may be particularly difficult in some circumstances, and therefore be more lenient in assessing whether not disclosing is "dishonest." While the Supreme Court did not consider this question in any detail, the majority does indicate some support for a contextual approach in stating that "the nature and extent of the duty to disclose, if any, will always have to be considered in the context of the particular facts presented."[59] This is consistent with guidelines for partner notification recognizing that the process of partner notification must consider the person's circumstances.[60] Those working in the public health field have also recognized that disclosure often cannot be made immediately after diagnosis and have, for example, assisted women in leaving abusive situations before their HIV-positive status is disclosed.

However, the existing body of criminal law likely applicable to such a question may be less amenable to acknowledging the difficulties surrounding disclosure in some circumstances. The closely related defences of *duress* and *necessity* are applicable in those situations in which a person's otherwise criminal conduct is "morally involuntary" and lacks "moral blameworthiness" because, in the circumstances, they lack any other "realistic choice."

In the case of the common law defence of *duress*,[61] the court will consider whether the person accused of a crime (eg, assault for engaging in sexual activity without disclosing HIV-positive status) was acting solely under

[58] *Cuerrier*, supra, note 1 at 54-55.

[59] Ibid at 50.

[60] Federal/Provincial/Territorial Advisory Committee on AIDS. *Guidelines for Practice for Partner Notification in HIV/AIDS*. Ottawa: Minister of Health, 1997.

[61] The statutory defence of duress set out in s 17 of the *Criminal Code* is not available when the accused is charged with certain specific offences (eg, aggravated assault or sexual assault), and is therefore not likely to apply in most cases where a person is criminally prosecuted for exposing another person to the risk of HIV infection.

compulsion of threats of death or serious bodily harm to herself or another person, whether she believed they would be carried out, whether they were so serious that they might have caused a reasonable person in the same situation to act in the same manner, and whether the accused had an "obvious safe avenue of escape."[62]

In the case of the defence of *necessity*, the court will consider whether the person faced "imminent risk" (not limited to the threat of bodily harm) and there was "no reasonable legal alternative to disobeying the law."[63] The defence also requires that "the harm inflicted must be less than the harm sought to be avoided."[64] Finally, this defence is not available where the dangerous situation was clearly foreseeable to the reasonable person and should therefore have been avoided at an earlier time.

Whether an HIV-positive person facing criminal charges based on their non-disclosure advance either of these existing defences, or argue for a contextual approach to analyzing the "dishonesty" of non-disclosure, or both, courts will inevitably end up assessing the accused person's conduct in the circumstances surrounding the non-disclosure. Is the accused credible in claiming she feared threats of violence would be carried out were she to disclose? Could she have withdrawn from the relationship before engaging in unprotected sex without disclosing? Was there some alternative course of action that would not have placed the other person at "significant" risk of HIV infection? Would a reasonable person have acted similarly in light of the threats of harm?

These are difficult criteria to satisfy in most circumstances. While some courts may have some understanding for HIV-positive people who does not disclose their status before unprotected sex because they fear physical violence from their partner, no solid legal conclusion can be offered at this point as to whether such a defence would succeed, and this uncertainty should be acknowledged.

Recommendations

Recommendation 5

> *Courts should adopt a contextual approach in interpreting and applying* Cuerrier. *Such an approach should include a recognition that, even if an activity poses a "significant risk" of transmitting HIV, an objective assessment of whether not disclosing is "dishonest" should be made only in light of all the circumstances of the case. Where an HIV-positive person honestly believes there is a risk of physical violence to them if they disclose their status to a sexual partner, then it should not be considered "dishonesty" sustaining criminal liability if they do not disclose their status. A contextual analysis should not necessarily be limited to the risk of physical violence; all the circumstances of the case should be assessed in determining whether not disclosing was "objectively dishonest," and other adverse consequences of disclosure may suffice to relieve against a duty to disclose.*

Recommendation 6

> *Education about the* Cuerrier *decision for people with HIV/AIDS should not advise people that the risk of physical violence or other*

[62] *R* v *Ruzic* (1998), 128 CCC (3d) 97 (Ont CA), leave to appeal granted March 25, 1999, SCC Bulletin 1999, at 492.

[63] *R* v *Perka*, [1984] 2 SCR 233, 14 CCC (3d) 385.

[64] Ibid.

adverse consequences relieves them of any duty to disclose their status if an activity poses a significant risk of transmission, but rather should indicate that the law is unclear in this area. Public health workers and counselors at other organizations need to assist people with HIV/AIDS to reduce the risk of violence or other adverse consequences in these circumstances so as to facilitate disclosure, which may be required by law.

How far does a duty of disclosure extend?

"Wilful ignorance" and a duty to disclose

As *Cuerrier* criminalizes non-disclosure of HIV-positive status, it would appear that someone could only be convicted of assault if they have actual knowledge of their HIV infection. However, it is theoretically possible that a prosecutor might, in a future case, seek to expand the scope of criminal liability to someone who was "wilfully ignorant" as to whether or not they are HIV-positive and whose conduct posed a significant risk of transmission to another. The most obvious scenario might be that of a person who has frequently engaged in high-risk activities and manifests symptoms likely indicative of HIV infection, and who either gets tested but does not return for results, or avoids getting tested altogether and therefore does not have a confirmed diagnosis. In criminal law, the concept of "wilful ignorance" (generally referred to as "wilful blindness") operates to impute knowledge to an accused person on the basis that they have "shut their eyes to the obvious" and have deliberately avoided making further inquiries in order to avoid acquiring actual knowledge.[65]

In characterizing non-disclosure of known HIV-positive status as "dishonesty," the Court ruled:

> A consent that is not based upon *knowledge of the significant relevant factors* is not a valid consent. The extent of the duty to disclose will increase with the risks attendant upon the act of intercourse. To put it in the context of fraud, the greater the risk of deprivation [ie, harm] the higher the duty of disclosure. The failure to disclose HIV-positive status can lead to a devastating illness with fatal consequences. In those circumstances, there exists a positive duty to disclose. The nature and extent of the duty to disclose, if any, will always have to be considered in the context of the particular facts presented.[66] [emphasis added]

This raises the question: what are the "significant relevant factors" upon which consent to sexual activity is based? Is it only known HIV-positive status (or infection with another STD that poses a "significant risk of serious bodily harm") that needs to be disclosed in order to ensure a sexual partner's valid consent? Could the underlying principle in *Cuerrier* be invoked in support of a prosecution argument that a person who is wilfully ignorant of their infection with HIV or another serious STD vitiates their partner's consent to sex if they do not "put their partner on notice" that they *may* be infected? It is arguable that, to many people, knowing that their sexual partner had signs or suspicions of HIV/STD infection could be a "significant relevant factor" in deciding whether to engage in certain kinds of sexual activity. That their partner does not know for certain

[65] *R* v *Sansregret*, [1985] 1 SCR 570.

[66] *Cuerrier*, supra, note 1 at 50.

that they are HIV-positive does not make the actual risk of transmission any less "significant."

Taking the criminal law to such a conclusion could, in effect, mandate disclosure of not merely known HIV-positive status but of past high-risk behaviours and/or other factors that may mean the person is HIV-positive. It is questionable whether the offence of assault could or should be stretched so far as to criminalize non-disclosure of not just a known infection, but even non-disclosure of facts giving rise to a suspicion of infection. It could be theoretically possible on a traditional criminal law analysis, and there may well be future cases in which the prosecution advances such an argument. However, expanding the law of assault this far would be to criminalize a vast number of sexual encounters and would render the law even more uncertain and impractical.

Indeed, the BC Court of Appeal in *Cuerrier* refused to develop the law of assault in this fashion. Its ruling on this point about "informed consent" was not considered by the Supreme Court; in overturning the BC Court of Appeal's decision, the Supreme Court reversed its ruling simply on the issue of whether non-disclosure could constitute a "fraud" under the criminal law. The BC Court of Appeal correctly refused to expand the scope of the criminal law this far:

> [A]s a matter of policy, I have grave reservations about importing the concept of informed consent, as it has been developed primarily in medical malpractice cases, into the criminal law of assault. There is a recognized legal duty on a doctor to inform his or her patient of risks associated with medical procedures in order to permit the patient to given an informed consent to treatment. There is no recognized duty, enforceable through the criminal law power of the state, which requires a person to provide full disclosure of all known risks associated with sexual intercourse to his or her sexual partner as a condition precedent to the partner giving an effective consent to sexual intercourse. The criminal law of assault is, indeed, an unusual instrument for attempting to ensure safe sex.... Taken to its logical conclusion, [such an approach] seeks to impose criminal liability on an accused for failure to make full disclosure of any information which could reasonably be relevant to the question of whether the complainants would consent to sexual intercourse.... [I] am of the view that such an approach is fraught with difficulties insofar as the criminal law of assault is concerned.[67]

Recommendation

Recommendation 7

> *Courts, prosecutors, and police should consider* Cuerrier *as requiring disclosure of HIV-positive status before engaging in activity posing a "significant" risk of transmission, if that status is known to the accused as a result of scientifically accepted confirmatory testing procedures. The decision should not be taken as extending a duty of disclosure beyond disclosure of a known HIV-positive status.*

[67] *Cuerrier*, supra, note 11 at 282-283 (BCCA, per Prowse JA).

Consent to sex is valid if disclosure is made

At one point, the prosecution in *Cuerrier* argued that for reasons of "public policy," the law should not recognize a person's consent to unprotected sex with an HIV-positive person even if they were aware of their partner's HIV-positive status. In making this argument, the prosecution relied upon a recent Supreme Court decision stating that, on "public policy" grounds, the law would not allow a person to legally consent to "serious hurt or non-trivial bodily harm."[68]

However, the Supreme Court rejected this argument. Its judgment in *Cuerrier* makes it clear that it is legally possible for a person to consent to engage in activity that carries a "significant risk" of HIV infection if they are aware of their partner's HIV-positive status. As already noted above, the Court ruled that:

> In situations such as that presented in this case, it must be emphasized that the Crown will still be required to prove beyond a reasonable doubt that the complainant would have refused to engage in unprotected sex with the accused if she had been advised that he was HIV-positive. As unlikely as that may appear, it remains a real possibility. In the words of other decisions it remains a live issue.[69]

The prosecution must prove *beyond a reasonable doubt* that the complainant would not have consented to unprotected sex had they known their partner's HIV-positive status.

Full disclosure likely required

As just noted above, the Court's majority emphasized that the prosecution must prove *beyond a reasonable doubt* that the complainant would not have consented to unprotected sex had they known their partner's HIV-positive status. Conceivably, this might allow what could be called a defence of "hypothetical consent."

For example, consider the situation in which an HIV-positive person, without actually disclosing their serostatus, engaged in a "hypothetical" exchange with their sexual partner. During that discussion, their partner indicates they would or might consent to engage in some "high risk" activity with a person they knew to be HIV-positive. In such a case, there is arguably a "reasonable doubt" about the claim that the partner would have refused unprotected sex if there had been actual disclosure by the HIV-positive person. After all, the partner has indicated their actual or possible willingness to run that risk. Such a scenario would be unusual, and the success of such a "hypothical consent" defence would depend greatly upon the credibility of those who were present for the discussion (most likely just the HIV-positive accused and the sexual partner).

However, this "hypothetical consent" argument would probably not succeed as a defence if all that could be established was that the sexual partner was willing to consent to high-risk sexual activity with a person who *might* be HIV-positive. After all, in *Cuerrier*, the Supreme Court rejected the argument that the two women gave valid consent to sex because, to their knowledge, Cuerrier *might* have been HIV-positive, the complainants were both aware of the risk of sexually transmitted diseases, and they ran the risk of possible HIV transmission by having unprotected sex with him. The Court stated that "true consent cannot be given if there has not been a disclosure by the accused of his

[68] *R v Jobidon*, [1991] 2 SCR 714, 66 CCC (3d) 454.

[69] *Cuerrier*, supra, note 1 at 51.

HIV-positive status."[70] In all likelihood, in order to raise a reasonable doubt as to the claim that the complainant would not have consented to sex if the accused had disclosed their HIV-positive status, credible evidence would be required establishing that the complainant indicated their consent to high-risk sex with a person they *knew* was HIV-positive (and not just *might* be).

Sharing Drug Injection Equipment

The current state of the law regarding criminal liability for non-disclosure of HIV-positive status has largely been developed in the context of unprotected sexual activity. As noted by one participant at the national workshop held to discuss the significance of the *Cuerrier* decision, counselors and advisers can offer some (albeit limited) guidance to HIV-positive people regarding a duty under the criminal law to disclose in the sexual context. However, the question of criminal liability in other contexts of possible HIV transmission is uncertain.

Because the *Cuerrier* decision is the most recent, and highest-level, decision of a Canadian court on the question of how the criminal law should treat the non-disclosure of HIV-positive status, some attempt is made below to analyze what implications the case *may* have in the realm of sharing injection equipment. Similarly, its implications (if any) regarding perinatal HIV transmission or HIV transmission in the context of medical procedures is also examined. This discussion is *not* intended as a definitive answer to the questions raised in these areas. Such an attempt would be premature, given the narrow confines of the *Cuerrier* case as one dealing with non-disclosure via sexual activity.

Furthermore, it bears repeating that the discussion below should not be considered an *encouragement* to pursue criminal prosecutions in any of the contexts considered. Reflecting concerns heard during the preparation of the Final Report on criminal law and HIV/AIDS, during the national consultations regarding the Canadian HIV/AIDS Strategy, and during the process of preparing this paper about the *Cuerrier* case, the Paper reiterates the conclusion and recommendation that criminal prosecutions should only ever be used as a measure of last resort, after all other, less intrusive measures (including those available under public health legislation) have been attempted without success.

Assault is an offence of limited application

The *Cuerrier* case dealt with an assault charge for engaging in unprotected sex without disclosing HIV infection. It is, therefore, a somewhat speculative exercise to predict how *Cuerrier* would be applied in the context of exposing another to the risk of HIV infection through sharing drug injection equipment.[71] The offence of assault is concerned with the application of force (ie, physical contact) without consent. But two different scenarios might be likely where someone is exposed to the risk of HIV infection through sharing of injection equipment.

HIV-positive person injects partner after using equipment

In the first scenario, an HIV-positive person directly injects their drug-sharing partner with the same, uncleaned equipment they have just used to inject themselves, without informing the other person of their HIV-positive status.

[70] Ibid at 50.

[71] The analysis set out here with respect to sharing injection equipment would apply equally to the scenario in which one person transfuses blood or bodily tissues known to contain HIV to another person without disclosing this fact, or inseminates that person with semen containing HIV. For cases tangentially relevant to such scenarios, see *R* v *Thornton*, supra, note 41; *ter Neuzen* v *Korn* (1995), 127 DLR (4th) 577 (SCC); *R* v *Tan*, unreported, 23 May 1995, Alta QB (Edmonton, Ritter J).

In this scenario, an assault charge could be upheld. The HIV-positive person has made direct physical contact with their otherwise consenting injecting partner. It could therefore be argued that consent to this contact was vitiated because the person did not disclose their HIV-positive status, and the partner being injected would not have consented to that injection with shared equipment had they known of the HIV-positive person's status. *Cuerrier* stands for the proposition that physical contact exposing another person to a bodily fluid containing HIV without their consent may be an assault.

The standard of a "significant risk" of transmission set out in *Cuerrier* is met where someone is injected using equipment previously used by an HIV-positive person. As noted in the current Canadian risk-assessment guidelines:

> The sharing of needles or syringes involves a very high potential for transmission of HIV due to the presence of blood in the shaft of the used needle and in the tube of the used syringe. Whether it is visible or not, blood will almost certainly be present in a used needle or syringe in sufficient quantities for transmission to occur. Infective HIV may remain present in the blood in a used needle or syringe for up to 24 hours. Sharing needles and syringes can also transmit other blood-borne viruses, such as Hepatitis B and C. These are of particular concern to people living with HIV.[72]

The standard of a "significant risk" of transmission set out in *Cuerrier* is met where someone is injected using equipment previously used by an HIV-positive person.

Direct injection of blood containing HIV is the most efficient route of infection, more so than the unprotected sex that was considered to present a "significant" risk of transmission in *Cuerrier*. There would, therefore, be a duty on the part of the HIV-positive participant to disclose their status to their injection partner if that partner is injected with the same equipment.

Partner self-injects with equipment used by HIV-positive person

In this second scenario, an HIV-positive person provides their used, uncleaned injection equipment to another person without disclosing their serostatus, and that person then uses the needle to inject themselves. The HIV-positive person does not perform the act of injecting the other person.

In this scenario there is no physical contact between the HIV-positive person and their injecting partner. Since the crime of assault requires the "application of force" (ie, physical contact), it seems unlikely that any assault has been committed. This means that criminal liability for essentially the same conduct with the same risk could thus turn on the "technicality" of which person actually performed the act of injecting with the used equipment.[73] However, charges under other provisions of the *Criminal Code* might lie (eg, *common nuisance* or *criminal negligence causing bodily harm*). As noted above, a person commits the offence of *common nuisance* (*Criminal Code*, s 180) if they do something unlawful, or fail to do something they have a legal duty to do, thereby endangering the lives, safety, or health of the public or causing injury to someone. A person is *criminally negligent* (*Criminal Code*, s 219) if in doing anything, or in failing to do something they have a duty to do, they show "wanton and reckless disregard" for the lives or safety of others.

Given that an *assault* charge is not legally sustainable in this second scenario, the discussion that follows about whether disclosure of HIV-positive

[72] *HIV Transmission: Guidelines for Assessing Risk*, supra, note 35 at 33.

[73] In 1998, a case was reported in New Zealand in which a man was committed to stand trial on charges of manslaughter for committing an unlawful and dangerous act in allegedly supplying a syringe to a person who then self-administered a lethal overdose of heroin. Supplying injection equipment containing HIV would seem susceptible to a similar argument by prosecutors. See: IDU manslaughter charge. [Australian] *HIV/AIDS Legal Link* 1998; 9(2): 5.

status and/or cleaning of injection equipment might be adequate to avoid criminal liability only applies to the first scenario, in which someone directly injects another person with contaminated equipment. In such a scenario, simply cleaning that equipment may not be adequate to relieve the HIV-positive person from their duty to disclose. It may also be that simply disclosing HIV-positive status is not sufficient on its own. While it is recommended below that the person who *both* discloses *and* cleans shared equipment should not face criminal liability, this question remains open. The only sure way to avoid criminal liability is to not share injection equipment at all, in which case there is no risk of HIV transmission, and therefore no duty to disclose.

Cleaning shared equipment *may* not suffice

In the *Cuerrier* case, referring specifically to condom use, the Supreme Court suggested that taking precautions might be adequate to reduce the risk of HIV transmission below the level of "significant" – and that there would therefore be no duty to disclose HIV-positive status. How might this analysis apply to an HIV-positive person who shares injection equipment? Are there precautions that could be taken to sufficiently reduce the risk of transmission so that it *might* no longer be considered (legally) "significant"? If so, then following the Court's reasoning in *Cuerrier*, this should mean that the HIV-positive person who takes such precautions when sharing injection equipment *may* not be required to disclose their HIV status in order to avoid criminal liability for exposing their injection partner to the risk of infection.

Current Canadian risk-assessment guidelines classify "injection using shared, cleaned needle and/or syringe and/or mixing equipment" as "low risk."[74] However, the primary public health message is and must be to avoid sharing injection equipment at all where possible. It was noted by both the Expert Committee on AIDS and Prisons[75] and in *HIV/AIDS in Prisons: Final Report*[76] that bleach is of questionable efficacy in destroying HIV:

> As jointly stated by the [US] Centers for Disease Control and Prevention, the Center for Substance Abuse Treatment, and the National Institute on Drug Abuse, "based on recent research, bleach disinfection should be considered as a method to reduce the risk of HIV infection from re-using or sharing needles and syringes (and other injection equipment) **when no other safer options are available.**"[77]

This assessment of risk is reiterated in Canada's risk-assessment guidelines:

> It is well established that the sharing of needles and syringes poses a high risk of transmission of HIV and other blood-borne viruses. To reduce the risk, a new needle and syringe should be used every time. If sharing a needle or syringe is absolutely unavoidable, it is essential that it be cleaned using bleach and water.[78]

In addition to concerns as to whether bleach is effective in destroying HIV, there is also concern that adequate cleaning of "works" is rare in practice; there is evidence of the transmission of HIV through the sharing of injection equipment, despite attempts at cleaning between users.

[74] *HIV Transmission: Guidelines for Assessing Risk*, supra, note 35 at 34.

[75] Correctional Service Canada. *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons.* Ottawa: Minister of Supply and Services Canada, 1994.

[76] R Jürgens. *HIV/AIDS in Prisons: Final Report.* Montreal: Canadian HIV/AIDS Legal Network & Canadian AIDS Society, 1996.

[77] US Department of Health & Human Services, Public Health Service, Centers for Disease Control and Prevention. *HIV/AIDS Prevention Bulletin*, 19 April 1993 [emphasis in original], cited in *HIV/AIDS in Prisons: Final Report*, supra, note 76 at 53.

[78] *HIV Transmission: Guidelines for Assessing Risk*, supra, note 35 at 33. The Guidelines add: "It is very important to note that there are serious doubts whether this cleaning method is adequate for the purpose of killing the Hepatitis C virus" (at 34).

However, if there is no or limited access to sterile injection equipment, the HIV-positive injection drug user confronts no safer option for reducing the risk of transmission than to clean injection equipment shared with others. This is currently the case in Canadian prisons. But at the same time, disclosure of HIV-positive status "inside" may carry serious risks to personal safety and may not be a realistic option. The *Cuerrier* decision therefore poses a particular dilemma for HIV-positive prisoners who use injection drugs, and highlights the importance of providing prisoners with access to clean injection equipment. Doing so would enable them to follow recommended risk-reduction practices. Denying access to clean injection equipment is not only substandard health care, but also means an additional risk of criminal prosecution for HIV-positive prisoners who cannot realistically be expected to disclose their status but have no access to their own clean equipment for injecting drugs.

The *Cuerrier* decision poses a particular dilemma for HIV-positive prisoners who use injection drugs, and highlights the importance of providing prisoners with access to clean injection equipment.

If the courts are willing to adopt a sophisticated, contextual approach to *Cuerrier*, it might be argued that in such circumstances there should be no criminal liability for HIV-positive prisoners who do not disclose their status, but who do comply with existing public health advice by cleaning shared injection equipment, given that the safer option of clean, unshared equipment is not available.

However, injection drug users with HIV/AIDS also need to be advised that this may be an unlikely outcome. Given the stigma surrounding HIV/AIDS and injection drug use, there is likely to be little understanding for those who share injection equipment knowing they are HIV-positive and without disclosing this. HIV-positive people may very well risk criminal prosecution for sharing injection equipment without disclosing their status, even if they take precautions to clean shared equipment. Those commenting on an earlier draft of this Paper disagreed over whether HIV-positive people who do not disclose their status before sharing injection equipment, but who do clean the "works," should be subject to criminal liability.

Disclosing before sharing equipment *may* not suffice

In the context of *sexual* risk-taking that was presented in *Cuerrier*, the Supreme Court was willing to accept that someone could, after being informed of a partner's HIV-positive status, consent to engage in unprotected sex and the associated risks. However, it is not clear that a court would reach the same conclusion in the context of consenting to share drug injection equipment with an injecting partner known to be HIV-positive.

In its decision in the *Jobidon* case, the Supreme Court ruled that on "public policy" grounds, the law should not give effect to a person's consent to "serious hurt or non-trivial bodily harm."[79] In addition, the *Criminal Code* (s 14) provides: "No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given."[80] Both the *Jobidon* rule and this provision in the *Criminal Code* were cited approvingly by the Supreme Court in the *Rodriguez*[81] case, in which the Court rejected a constitutional challenge to the prohibition of assisted suicide.

However, this rule against consenting to serious hurt must be considered in the context of the *Jobidon* case in which it was formulated; the Court's statements in the judgment are important to understanding how courts dealing with

[79] *Jobidon*, supra, note 68.

[80] *Criminal Code*, supra, note 8, s 14.

[81] *Re Rodriguez and Attorney General of British Columbia*, [1993] 3 SCR 519, 17 CRR (2d) 193.

other cases may interpret this "public policy" limitation on what kind of physical injury people can and cannot consent to. This is particularly important for the purposes of the discussion in this Paper, as the *Jobidon* case was raised before the Supreme Court in *Cuerrier*, and the prosecution argument based on it was rejected by the Court.

In *Jobidon*, the accused and another man had agreed to a fistfight in a parking lot outside a bar. In the course of that fight, the accused delivered a blow that resulted in the other man's death. The accused was charged with assault, but argued that the other combatant had consented to engage in the fight, and that he should therefore not be held criminally liable. The prosecution argued that, for reasons of "public policy," the law should not recognize this consent as a valid defence to an assault charge. The Supreme Court agreed, ruling that there could be no valid consent to the infliction of "serious hurt or non-trivial bodily harm" in the course of a fistfight or brawl, as these were activities the law had no interest in condoning or encouraging. Therefore, the law will not excuse a person from criminal liability for inflicting serious hurt on someone in a fight simply because the other person consented to the fight.

The Court recognized that other activities to which people regularly consent also carry the risk of serious physical harm – such as rough sporting activities, medical or surgical treatment, professional stunt activities, etc. However, the Court was of the view that, unlike fistfights and brawls, these activities have some social value. Therefore, the law will recognize a person's freely given consent to the risk of "serious hurt or non-trivial harm" that accompanies socially useful activities. The *Jobidon* case suggests that Canadians can only knowingly consent to the risk of serious harm if that risk accompanies some socially useful activity.

Sexual activity has recognized social utility.[82] In *Cuerrier,* the prosecution suggested that a person could not give valid consent to engage in sex with a person known to be HIV-positive. (It subsequently softened its position, saying that legally valid consent could not be given to *unprotected* sex with an HIV-positive person.) Such an argument would essentially criminalize any sexual activity by HIV-positive people, even with consenting partners fully aware of their status. Fortunately, as noted above, the Court rejected this argument, ruling that a person could still give legally recognized consent to sex:

> [I]t must be emphasized that the Crown will still be required to prove beyond a reasonable doubt that the complainant would have refused to engage in unprotected sex with the accused if she had been advised that he was HIV-positive. As unlikely as that may appear it remains a real possibility. In the words of other decisions it remains a live issue.... It must be remembered that what is being considered is a consensual sexual activity which would not constitute assault were it not for the effect of fraud. Obviously if the act of intercourse or other sexual activity was consensual it could not be an assault. It is only because the consent was obtained by fraud that it is vitiated.[83]

However, it seems unlikely that courts will treat injection drug use carrying a risk of harm in the same restrained fashion as sexual activity carrying a risk of harm. The possession of many injected drugs remains a criminal offence in

[82] Note, however, that the British House of Lords has ruled that consent to participate in sadomasochistic sexual activities is not legally valid: *R* v *Brown*, [1993] 2 All ER 75 (HL). Citing both *Jobidon* and *Brown*, the Ontario Court of Appeal has also ruled that consent to "non-trivial harm" through sex is not legally recognized: *R* v *Welch* (1995), 43 CR (4th) 225 (Ont CA).

[83] *Cuerrier*, supra, note 1 at 51.

Canada. This would likely be considered a strong expression by Parliament of contemporary social standards in Canada to the effect that the use of illicit drugs is considered not simply lacking in social utility, but anti-social activity. *Cuerrier* indicates that a person may legally consent to the risk of HIV infection through unprotected sex with a person they know to be HIV-positive. But a court could rule, as a matter of "public policy," that it is not possible to legally consent to being injected using equipment already used by a person known to be HIV-positive.

Cuerrier indicates that a person may legally consent to the risk of HIV infection through unprotected sex with a person they know to be HIV-positive. But a court could rule, as a matter of "public policy," that it is not possible to legally consent to being injected using equipment already used by a person known to be HIV-positive.

Both cleaning shared equipment *and* disclosure *may* be required

The conclusion noted above was that simply cleaning shared injection equipment may not be considered by the courts to sufficiently reduce the risk of HIV transmission. Therefore, as the risk may not fall below the level of "significant" through cleaning, the duty to disclose HIV-positive status will still arise.

However, it has also been concluded in the preceding section that simply disclosing HIV-positive status to the person being injected with shared equipment will not remove criminal liability, because the law would not likely accept as valid a person's consent to the serious harm of being injected with HIV-contaminated blood from the used injection equipment.

However, if an HIV-positive injection drug user both discloses their status to the person sharing their equipment, *and* takes the risk-reduction precaution of properly cleaning the equipment, then there is an argument to be made that no criminal liability should be imposed. If there has been both disclosure of status and cleaning of injection equipment, then the person sharing the equipment is knowingly running a reduced risk of transmission. The law is not so paternalistic as to prevent us from knowingly running any and all risks of harm. People regularly run the risk of death or serious injury in everyday activities (eg, driving a vehicle, participating in some sporting or recreational activities) and there is no criminal liability imposed on the party who coordinates or offers such activities to participants with disclosure of the risks involved.

To criminalize the HIV-positive person who shares injection equipment, even if they disclose their status to the person(s) sharing their equipment *and* clean that equipment to reduce the risk of transmission, is to penalize responsible behaviour that demonstrates a concern for the welfare of others and complies with accepted public health recommendations. Extending the criminal law this far would be ethically indefensible, would trivialize the significance of a criminal prosecution, and would undermine sound public health policy. There was agreement from those commenting on this point that the law should not be extended this far.

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Recommendations

Recommendation 8

Education for people living with HIV/AIDS should include the following:

- *Assault charges could be upheld where an HIV-positive person directly injects another person with used injection equipment, and probably do not apply where the HIV-positive person's injecting partner injects themselves. However, other criminal charges might*

be laid in circumstances where an HIV-positive person does not directly inject another, but provides contaminated injection equipment without disclosing their serostatus.

- *Because of doubts about its efficacy as a precaution, cleaning injection equipment before another person uses it to inject* may *not be sufficient on its own to avoid criminal liability. If injection equipment is shared at all, even if cleaned between users, an HIV-positive person may still have a duty to disclose their serostatus to the person using their equipment.*
- *Disclosing HIV-positive status to a person who shares injection equipment may also not be, on its own, an adequate defence to criminal liability, because Canadian law may not recognize as valid the other person's consent to having someone else infect them with HIV.*
- *Both disclosure of HIV-positive status* and *cleaning injection equipment* may *be sufficient to avoid criminal liability, but this has not yet been decided by the courts.*
- *Eliminating the risk of HIV transmission entirely by not sharing injection equipment is the only sure way for an HIV-positive person to avoid criminal liability.*

Recommendation 9

Courts and prosecutors should accept, at least, that there is no criminal liability attaching to the person who both discloses their HIV-positive status and *cleans injection equipment before its use to inject another. This recognizes the prerogative of their equipment-sharing partner to choose to run the known, low risk that they may be infected through the use of that equipment. Imposing criminal liability where the HIV-positive person both discloses and cleans the equipment would overextend the criminal law and undermine sound public health policy.*

Mother–Infant Transmission[84]

Perinatal transmission from an HIV-positive mother to her infant may occur in three circumstances:

- in the uterus before birth (intrauterine, transmission in utero);
- during delivery (intrapartum); and
- through breast-feeding after birth (postpartum).

There has not to date been any proposal in Canada to criminally prosecute HIV-positive mothers for intrauterine or intrapartum transmission to their infants, and there are strong ethical, legal, and practical arguments against any such move. Calls for such penalties have been made in some US jurisdictions, and commentators have been critical of a number of "HIV transmission" or "HIV exposure" laws in some states that could conceivably be interpreted this broadly. Most commentators have generally concluded that such an application of criminal statutes is not defensible because of the absence of any legislative intent to impose criminal liability for the risk of perinatal

[84] Much of the background information in this section is drawn from L Stoltz, L Shap. *HIV Testing and Pregnancy: Legal and Medical Parameters of the Policy Debate*. Ottawa: Health Canada, 1999; and Jürgens, supra, note 6.

transmission, and the wording of some of these statutes is perhaps unconstitutionally vague. Commentators also note that the fetus is not generally recognized as a "person" in US law. Finally, they point out that these statutes might be unconstitutionally discriminatory on gender and/or racial lines, would disproportionately affect indigent women, and would likely deter those women most in need from seeking health and support services, to the detriment of both their health and that of their fetuses.[85]

However, as this Paper is intended to (a) address concerns and provide information about the significance – real or perceived – of the *Cuerrier* case, and (b) to make recommendations directed at preventing the detrimental misapplication of *Cuerrier*, this issue of perinatal transmission is discussed briefly below.

The *Cuerrier* case considered the applicability of the assault provisions of the *Criminal Code* to the conduct of an HIV-positive person who does not disclose their status before engaging in unprotected sexual intercourse. The question before the Court was whether the non-disclosure is a "fraud" that renders the sexual partner's consent to sex legally invalid. However, the circumstances of transmission during pregnancy or delivery are obviously different from otherwise consensual sex between adults, and the analysis in *Cuerrier* does not translate easily into this context. From an ethical and legal standpoint, intrauterine and intrapartum transmission are analyzed jointly below. Transmission via breast-feeding, however, involves different considerations, and is therefore discussed separately.

The conclusion offered below is that the *Cuerrier* decision does not provide any support for criminal prosecution of HIV-positive women for transmission to a fetus during pregnancy or during delivery. However, as a matter of legal interpretation, *Cuerrier* suggests that an HIV-positive mother *may* risk criminal prosecution for assault if she breast-feeds her infant. It is also noted that other offences in the *Criminal Code* arguably already apply to this scenario, and *Cuerrier* does not change this existing state of affairs.

The *Cuerrier* decision does not provide any support for criminal prosecution of HIV-positive women for transmission to a fetus during pregnancy or during delivery.

Risk of transmission in utero and during delivery

For a number of reasons, *Cuerrier* does not provide a legal basis for criminally prosecuting an HIV-positive woman for assault based on the risk of transmitting the virus to her infant during pregnancy or delivery.

First, it makes no sense to speak of whether the fetus' consent to physical connection with the mother is contingent upon disclosure by her of her HIV-positive status. As there is no person whose consent could be considered vitiated by the non-disclosure, it would therefore be stretching the offence of assault and the analysis of fraud in *Cuerrier* to criminally prosecute an HIV-positive mother for exposing an infant to the risk of infection *in utero* or during delivery.

Second, such a criminal prosecution would be ethically unjustifiable. A person cannot be held criminally liable for a risk of harm to another person over which they do not ultimately exercise control; there is no moral wrong calling for sanction. While interventions during pregnancy such as a regimen of antiretroviral therapy and/or caesarian section may significantly reduce the risk of HIV transmission from mother to fetus, they cannot eliminate that risk, or even lower it to a statistical level comparable to the "low risk" of an activity

[85] See: K Boockvar. Beyond survival: the procreative rights of women with HIV. *Boston College Third World Law Journal* 1994; 14: 1; MA Field. Pregnancy and AIDS. *Maryland Law Review* 1993; 52: 402; H Sprintz. The criminalization of perinatal AIDS transmission. *Health Matrix* 1993; 3: 495; S Sangree. Control of childbearing by HIV-positive women: some responses to emerging legal policies. *Buffalo Law Review* 1993; 41: 309.

such as protected intercourse. Furthermore, while a recent study revealed no apparent indication of zidovudine (AZT) toxicity in children whose mothers follow such a regimen,[86] Stoltz and Shap point out that

> there is a paucity of data regarding the short-term and long-term effects in women and their infants of antiretroviral prophylaxis to reduce perinatal HIV transmission. The demonstrated ability of this therapy to reduce the risk of perinatal HIV transmission and its devastating consequences is unquestionably significant. In developing an approach to the care and treatment of pregnant women to minimize the risk of perinatal HIV transmission, however, physicians and policymakers must equally bear in mind the potential seriousness of its known and unknown risks. The public health disasters of thalidomide and diethylstilbesterol (commonly referred to as "DES") serve as powerful reminders of the possibility of harm presented by the use of therapeutic drugs during pregnancy.[87]

Finally, an assault charge would not be legally sustainable if laid against an HIV-positive woman for the risk of infection to her fetus during pregnancy or delivery, as the fetus is not a legal person in Canadian law. Section 223(1) of the *Criminal Code* provides that:

> A child becomes a human being within the meaning of this Act when it has completely proceeded, in a living state, from the body of its mother whether or not
>
> (a) it has breathed,
> (b) it has an independent circulation, or
> (c) the navel string is severed.

Canadian jurisprudence is also clear in this regard:

- In *R* v *Morgentaler*[88] and in *Tremblay* v *Daigle*,[89] the Supreme Court has ruled that a pregnant woman's control over her own body includes the right to terminate pregnancy. In the *Tremblay* v *Daigle* case, in rejecting a man's request for an injunction preventing his former partner from obtaining an abortion, the Supreme Court ruled that a fetus does not have legal personhood under either the Québec *Charter of Human Rights and Freedoms* or the *Civil Code of Québec*, nor does Anglo-Canadian law grant the fetus any rights unless born alive.
- In *Sullivan*,[90] the Supreme Court ruled that a fetus is not a "human being" for the purposes of the *Criminal Code*. This finding regarding the status of the fetus in the criminal law has been repeated by trial courts in both British Columbia (*Manning*) and Ontario (*Drummond*).[91]

Finally, in its most recent judgment addressing this point, the Supreme Court was asked to rule whether a pregnant Aboriginal mother addicted to inhalants could be detained against her will, by court order, in a health centre for treatment until the birth of her child. In refusing such a request, the Court expressed its concern that such a punitive approach might drive underground those women most in need of prenatal care and assistance (thereby harming both mother and child), and that such an extension of the law would fall most

[86] M Culname et al. Lack of long-term effects among uninfected children exposed to zidovudine. *Journal of the American Medical Association* 1999; 281: 151-157.

[87] Stoltz & Shap, supra, note 84 at 21, and see discussion at 14-21.

[88] *R* v *Morgentaler*, [1988] 1 SCR 30.

[89] [1989] 2 SCR 530.

[90] *R* v *Sullivan* (1991), 63 DLR (3d) 97 (SCC) at 106.

[91] *R* v *Manning*, [1994] BCJ No 1732 (Prov Ct); *R* v *Drummond* (1996), 112 CCC (3d) 481 (Ont Ct Prov Div).

heavily upon "minority women, illiterate women, and women of limited education." The Court reiterated that "the position is clear" that Canadian law does not recognize the fetus as a legal person possessing rights; "this principle applies generally.… Any right or interest the foetus may have remains inchoate and incomplete until the birth of the child."[92] It therefore refused to order detention and forced treatment of the pregnant woman in question. (This legal state of affairs could theoretically be changed via legislation, as was contemplated by the Supreme Court in its judgment.)

Cuerrier should not be seen as encouraging criminal prosecutions for HIV transmission during pregnancy or delivery. In its 1993 report, the Royal Commission on New Reproductive Technologies concluded that

> trying to use the law and the courts to protect foetal health can only be counterproductive. Such laws may, on the surface, have appeal, because we all support the goal of the well-being of the foetus, and enacting them may appear to be a logical extension of society's interest in the health of the foetus. But there is nothing in our experience to demonstrate that such laws work in practice. Indeed, there is strong evidence to the contrary, particularly because the instruments available to the courts – forcing action under penalty of fines or incarceration – are brutally blunt and patently unsuited to the goal of promoting anyone's health or well-being. Clearly, if protecting the foetus is the goal, other methods are needed.... Because the woman's consent and cooperation are needed to ensure a positive outcome for the foetus, it follows that the most efficient way of caring for the foetus is through appropriate support and caring for the pregnant woman. The Commission therefore recommends that
>
> … Judicial intervention in pregnancy and birth not be permissible. Specifically, the Commission recommends that
>
> (a) medical treatment never be imposed upon a pregnant woman against her wishes;
> (b) the criminal law, or any other law, never be used to confine or imprison a pregnant woman in the interests of her foetus;
> (c) the conduct of a pregnant woman in relation to her foetus not be criminalized;
> (d) child welfare or other legislation never be used to control a woman's behaviour during pregnancy or birth; and
> (e) civil liability never be imposed upon a woman for harm done to her foetus during pregnancy.[93]

If proposals are ever advanced in Canada for the criminalization of perinatal transmission, policy- and decision-makers would do well to heed these recommendations and the concerns expressed by the Supreme Court in *Winnipeg CFS* v *DFG*. We must also remember the ethical imperative to treat people as ends in themselves, and not merely as means to ends. As one commentator reminds us:

> A woman's right to control medical decisions that implicate her body and her health does not end because she is pregnant. She

[92] *Winnipeg Child and Family Services (Northwest Area)* v *DFG*, [1997] 3 SCR 925, [1997] SCJ No 96 (QL) at para 15.

[93] *Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies*, Vol 2 (Ottawa: Minister of Government Services Canada, 1993), at 949, cited in Stoltz & Shap, supra, note 84 at 31.

> should be treated as an individual in her own right, and not simply as a vessel for fetuses. Nor should she be conceptualized as simply the conveyor of disease.[94]

Risk of transmission through breast-feeding

As summarized by Gostin and Lazzarini in their recent, leading text:

> The World Health Organization has drawn attention to breast-feeding/breast milk as a route of HIV transmission. Increasing evidence suggests that HIV may be transmitted postpartally through breast milk. Vertical transmission has been noted among women known to be infected prior to giving birth (prevalent cases) and among those who became infected while nursing (incident cases).… Transmission via breast-feeding is thought to occur during the first three months after birth.… A meta-analysis of epidemiological evidence has found that breast-feeding increases the risk of HIV transmission by fourteen percent for prevalent cases and by twenty-nine percent for incident cases.… Although these findings have been criticized, a consensus of the scientific community believes that breast-feeding poses a risk of HIV transmission..… The precise level of risk, however, has yet to be determined.[95]

Assault charge may *apply*

Given that breast-feeding poses a risk of HIV transmission, the question arises: does *Cuerrier* have any application to this conduct? In considering this question whether an HIV-positive mother could be held criminally liable for breast-feeding, it needs to be acknowledged that both the ethical and legal landscape alter once a child has been delivered.

An intervention aimed at promoting fetal health necessarily involves interfering with the bodily integrity, well-being, privacy, and autonomy of the pregnant woman carrying that fetus, and a conflict between these interests may sometimes arise. In contrast, an intervention after birth with respect to breast-feeding does not necessarily infringe upon the mother's interests and rights in the same way or to the same degree; the child is a physically separate being whose physical well-being is not as dependent upon that of its mother. Furthermore, while interventions during pregnancy or delivery such as drug therapy or caesarian section reduce the risk of HIV transmission, the pregnant woman is (currently) unable to lower the risk to a statistically insignificant level. In contrast, refraining from breast-feeding after birth completely eliminates the risk of transmission. For these reasons, intervention after birth to prevent HIV transmission is therefore more ethically defensible.

From a legal perspective, a child once born is obviously recognized as a "person" in law. Traditional legal principles governing conduct that harms or risks harm to other "persons" become applicable. Existing legal regimes (including child protection legislation, public health statutes, and the criminal law) already govern parent–child relationships in various ways. Unlike forced medical treatment during pregnancy, prohibiting breast-feeding to prevent a risk of harm to the child does not inevitably infringe the mother's bodily autonomy and freedom more than other, already permitted interventions in parental

[94] Field, supra, note 85.

[95] L Gostin, Z Lazzarini. *Human Rights and Public Health in the AIDS Pandemic*. New York: Oxford University Press, 1997, at 149-150, citing P Van de Perre et al. Mother-to-infant transmission of human immunodeficiency virus by breast milk: presumed innocent or presumed guilty? *Clinical Infectious Disease* 1992; 15: 502-507; P Van de Perre et al. Infective and anti-infective properties of breast milk from HIV-1-infected women. *Lancet* 1993; 341: 914-918; DT Dunn et al. Risk of human immunodeficiency virus type 1 transmission through breast-feeding. *Lancet* 1992; 340: 585-588; NA Halsey et al. Transmission of HIV-1 infections from mothers to infants in Haiti. *Journal of the American Medical Association* 1990; 264: 2088-2092; European Collaborative Study. Risk factors for mother-to-child transmission of HIV-1. *Lancet* 1992; 339: 1007-1012; AJ Ruff et al. Breast-feeding and maternal – infant transmission of human immunodeficiency virus type 1. *Journal of Pediatrics* 1992; 121: 325-327; and DJ Hu et al. HIV infection and breast-feeding: policy implications through a decision analysis model. *Journal of Acquired Immune Deficiency Syndrome* 1992; 6: 1505-1512.

conduct to prevent harm to children. Given that existing criminal laws apply to govern a parent's conduct toward a child, what is the effect of the *Cuerrier* decision in the context of breast-feeding by an HIV-positive mother?

Cuerrier primarily settles the narrow legal question of whether non-disclosure of HIV-positive status may constitute a "fraud" that vitiates a sexual partner's consent to unprotected sex. However, decisions of the Supreme Court are often interpreted as setting out broader principles that guide the development of the law beyond the confines of the particular case. More broadly understood, *Cuerrier* stands for the general proposition that criminal liability attaches to conduct that exposes another to a "significant" risk of infection without their knowingly consenting to that risk.

More broadly understood, *Cuerrier* stands for the general proposition that criminal liability attaches to conduct that exposes another to a "significant" risk of infection without their knowingly consenting to that risk.

The act of breast-feeding constitutes a physical contact between mother and child. As noted, this contact increases the risk of HIV transmission (by as much as 29 percent according to available evidence cited by Gostin and Lazzarini). While "the precise level of risk has yet to be determined," there is some risk. Current Canadian risk-assessment guidelines advise:

> HIV is present in the breast-milk of lactating HIV-positive women. Infants may be at risk of HIV infection through breast-feeding, as the mucosal immunity in their mouths is not fully developed. In North America, it is recommended that HIV-positive mothers do not breast-feed infants.[96]

In light of the uncertainty regarding the level of risk associated with breast-feeding, current risk-assessment guidelines, and the *Cuerrier* decision, it may be the case that an HIV-positive mother who breast-feeds her infant risks criminal prosecution for assault. (Other *Criminal Code* offences might also apply more directly, such as *administering a noxious thing*, *common nuisance*, *criminal negligence causing bodily harm*, or *failing to provide the necessaries of life*.) *Cuerrier* therefore highlights the necessity of ensuring that HIV-positive mothers are able to access the information and support they need to avoid exposing their infants to this risk of infection, and of appropriately tailored public health interventions to encourage behaviour change.

It may be the case that an HIV-positive mother who breast-feeds her infant risks criminal prosecution for assault. *Cuerrier* therefore highlights the necessity of ensuring that HIV-positive mothers are able to access the information and support they need to avoid exposing their infants to this risk of infection, and of appropriately tailored public health interventions to encourage behaviour change.

Recommendations

Recommendation 10

> *Consistent with current guidelines, HIV-positive mothers should be counseled to refrain from breast-feeding their infants, and should also be aware that breast-feeding could carry the risk of criminal prosecution for assault (or other offences).*

Recommendation 11

> *Governments, health and social services officials, health-care workers, and organizations working with HIV-positive women should ensure that information and necessary supports are available to enable HIV-positive mothers to refrain from breast-feeding, including financial assistance where necessary to ensure access to substitutes for breast milk.*

[96] *HIV Transmission: Guidelines for Assessing Risk*, supra, note 35 at 35.

Risk of Transmission via Invasive Medical Procedures

The decision in *Cuerrier* deals specifically with the risk of exposure through sexual activity. However, it has obvious implications for exposure in the context of medical procedures where patient and health-care worker come into physical contact. In this section, the Paper:

- provides some background data in order to keep the level of risk in perspective;
- briefly discusses existing professional guidelines that provide guidance to health-care workers regarding risk reduction;
- identifies that *Cuerrier* may impose criminal liability on an HIV-positive person (either health-care worker or patient) if they do not disclose their status before a procedure posing a "significant risk" of transmission is conducted;
- proposes that proper observance of universal precautions may relieve the HIV-positive person involved in a medical procedure of the obligation (under criminal law) to disclose, and recommends that courts should expressly recognize this at law;
- briefly discusses the existing state of the law imposing civil tort liability on a health-care worker for not obtaining "informed consent" before conducting a medical procedure, and concludes that tort law establishes a much lower threshold for requiring disclosure than the criminal law;
- considers the relationship between the tort liability and criminal liability thresholds, and concludes that *Cuerrier*, while articulating the disclosure threshold for avoiding criminal liability, does not alter the already existing, lower threshold for avoiding civil liability; and
- offers conclusions and recommendations.

Assessing the risk of HIV transmission via medical procedures

The level of risk under discussion needs to be kept in perspective:

- The Proceedings of the [1996 Canadian] Consensus Conference on Infected Health Care Workers[97] report that "mathematical models of risk suggest that per 1,000,000 procedures by an infected health care worker" there may be "2.4 to 24 transmissions of HIV (average sporadic risk)."[98]
- The Proceedings also report only two documented instances of HIV transmission from a health-care worker to a patient (and it has been impossible to determine with absolute certainty that these cases of transmission were a result of invasive medical procedures).[99] The Canadian Medical Association has reported that there had been no instances in Canada of HIV infection in patients resulting from exposure to infected health-care workers.[100] The US Centers for Disease Control (CDC) reviewed reports concerning over 22,000 patients of 51 HIV-positive health-care workers and found no evidence of transmission.[101]
- The US CDC has estimated the rate of transmission of HIV from an infected doctor to a patient to be between 1 in 100,000 and 1 in 1,000,000 for a given surgical operation.[102] As noted in *HIV Testing and Confidentiality: Final Report*, the risk of transmission has been recognized as extremely low by

[97] Laboratory Centre for Disease Control (Health Canada). Proceedings of the Consensus Conference on Infected Health Care Workers: risk for transmission of bloodborne pathogens. *Canada Communicable Disease Report* 1998; 24(Suppl4): 9.

[98] Ibid, citing D Bell. Human immunodeficiency virus transmission in health care settings: risk and risk reduction. *American Journal of Medicine* 1991; 3B-294S – 3B-300S.

[99] See: Centers for Disease Control. Transmission of HIV infection during an invasive dental procedure, Florida. *Morbidity and Mortality Weekly Report* 1991; 40: 21-27,33; Centers for Disease Control. Update: investigations of persons treated by HIV-infected health care workers – United States. *Morbidity and Mortality Weekly Report* 1993; 42: 329-31; A Dorozynski. French patient contracts AIDS from surgeon. *British Medical Journal* 1997; 314: 250; A Blanchard et al. Molecular evidence for nosocomial transmission of human immunodeficiency virus from a surgeon to one of his patients. *Journal of Virology* 1998; 72(5): 4357-4550.

[100] Canadian Medical Association. HIV infection in the workplace. *Canadian Medical Association Journal* 1993; 148(10): 1800A-D.

[101] J Hoey. When the physician is the vector. Editorial. *Canadian Medical Association Journal* 1998; 159: 45-46, citing: DM Bell et al. Preventing bloodborne pathogen transmission from health-care workers to patients: the CDC perspective. *Surgical Clinics of North America* 1995; 1189-1203.

[102] T Mauth. Charter implications of compelling dentists to reveal their HIV status. *Health Law in Canada* 1996: 97-106 at 98, citing F Rhame. The HIV-infected surgeon. *Journal of the American Medical Association* 1990; 264(4): 507 at 508.

> the Ontario Law Reform Commission, and described as "infinitesimal"[103] by the Canadian AIDS Society and "vanishingly small" by one commentator citing statistical estimates from the US CDC (1/40,000 to 1/400,000 from HIV-positive surgeons and 1/200,000 to 1/2,000,000 from HIV-positive dentists).[104]

In any discussion of criminal liability for non-disclosure, we should remember that:

> We do not require the physician to disclose his psychiatric history, drug or alcohol abuse, stress factors, or his daily levels of fatigue, even though any of these factors are more relevant to patient safety than HIV status. Viewing HIV in the context of these other risks, it is placed in perspective.[105]

As for transmission from HIV-positive patient to health-care worker, "the estimated rate of seroconversion after a needle-stick injury involving a known HIV-positive patient is 0.3%."[106] There is some (questioned) evidence that zidovudine prophylaxis can reduce this risk by as much as 79 percent.[107] The US CDC reports 54 documented instances of health- care workers seroconverting to HIV following occupational exposure.[108] The Canadian Medical Association notes there has been only one case in Canada of HIV infection in a health-care worker resulting from occupational exposure and that this case occurred in a laboratory, not a patient-care setting.[109]

Despite this low risk, some health-care workers still refuse to treat patients known to be HIV-positive or considered to be "at risk" of being infected. A recently released study of Canadian dentists found that, contrary to Canadian Dental Association guidelines, roughly one in six dentists would refuse to treat HIV-infected patients; 37 percent also said they would be unwilling to treat patients with hepatitis B virus, and 35 percent would not treat injection drug users.[110] Courts in both Canada and the US have ruled that such a refusal violates anti-discrimination law, and that health-care providers cannot (ethically or legally) refuse care to HIV-positive persons because the risk of transmission is so low.[111]

What *is* clear is that much confusion and fear continues to surround the issue of medical procedures and the risk of HIV transmission. The *Cuerrier* decision should not be permitted to contribute to these misperceptions or justify misguided, and ultimately damaging, policies.

Potential for criminal liability for non-disclosure

What *Cuerrier* does add to the legal landscape is the possibility of *criminal* liability for the non-disclosure of HIV-positive status. It is already established that non-disclosure by an HIV-positive health-care worker may constitute a breach of professional ethics and standards in very limited circumstances (as discussed above), and may also result in *civil* liability (as discussed below). The new development represented by *Cuerrier* is the question of criminal liability for non-disclosure; unlike the issue of professional misconduct or civil liability, criminal sanction for non-disclosure is applicable not just to a health-care worker, but also to an HIV-positive patient in their interaction with a health-care worker. The criminal law would apply to both parties.

[103] Dr J Brookfield, cited in: Canadian AIDS Society. The Right of Health Care Workers with HIV to Practice their Profession without Restrictions: A Position Paper. Ottawa: CAS, 11 September 1992, at 4.

[104] R Bayer. Discrimination, informed consent, and the HIV infected clinician. *British Medical Journal* 1997; 314: 915-916, at 915, with reference to Centers for Disease Control and Prevention. *Estimates of the Risk of Transmission of Hepatitis B Virus and Human Immunodeficiency Virus to Patients by the Percutaneous Route during Invasive Surgical and Dental Procedures*. Atlanta: CDC, 1991, cited in Jürgens, supra, note 6 at 188.

[105] JK Lunde. Informed consent and the HIV-positive physician. *Medical Trial Technique Quarterly* 1992; 38: 186 at 197.

[106] CMA, supra, note 100, citing: [US] Centers for Disease Control. Case-control study of HIV seroconversion in health-care workers after percutaneous exposure to HIV-infected blood – France, United Kingdom, and United States, January 1988 – August 1994. *Morbidity and Mortality Weekly Report* 1995; 44(50): 929-933. See also: Ontario Medical Association Committee on HIV Infection. OMA support program for the physician infected with a blood-borne pathogen. *Ontario Medical Review*, February 1999: 25-30; JL Gerberding. Management of occupational exposure to bloodborne viruses. *New England Journal of Medicine* 1995; 332: 444-451; (3) JL Gerberding. Occupational HIV infection. *AIDS* 1997; 11(Suppl A): 557-560.

[107] D Patrick. HIV post-exposure prophylaxis: new recommendations. *Canadian Medical Association Journal* 1997; 156: 223, citing JI Tokars et al. Surveillance of HIV infection and zidovudine use among health care workers after occupational exposure to HIV-infected blood. *Annals of Internal Medicine* 1993; 118: 913-919; Case-control study of HIV seroconversion in health-care workers, supra, note 106.

[108] Centers for Disease Control. Reported Cases of AIDS and HIV Infection in Health Care Workers. Atlanta: CDC, 28 December 1998.

[109] CMA, supra, note 100.

[110] GM McCarthy et al. Factors associated with refusal to treat HIV-infected patients: the results of a national survey of dentists in Canada. *American Journal of Public Health* 1999; 89: 541-545.

[111] See: *Abbott* v *Bragdon*, 118 S Ct 2196 (1998); *Québec Human Rights Commission* v *Dr GG*, Québec Human Rights Tribunal, Québec City, No 200-53-000002-944, 11 April 1995 (Rivet J), reported in B Guillot-Hurtubise. Dentist found guilty of discrimination. *Canadian HIV/AIDS Policy & Law Newsletter* 1995; 1(4): 1, 14-15.

It is possible that *Cuerrier* could be interpreted as imposing a duty on both HIV-positive patients and HIV-positive health-care workers to disclose their status before any medical procedure is conducted that poses a "significant risk" of HIV transmission.

According to *Cuerrier*, a person's duty to disclose HIV-positive status is triggered when there is a "significant risk" of transmission arising from physical contact. The Supreme Court's judgment gives no consideration to the implication of its decision in *Cuerrier* in the context of medical procedures. However, if applied by a court in such a case, it is possible that *Cuerrier* could be interpreted as imposing a duty on both HIV-positive patients and HIV-positive health-care workers to disclose their status before any medical procedure is conducted that poses a "significant risk" of HIV transmission. Not disclosing in such a circumstance could be held to constitute a fraud that vitiates the other person's consent to engage in the procedure.

Observing professional guidelines

There are existing policies and guidelines adopted by professional bodies and public health experts that govern disclosure and practice by health-care workers who are HIV-positive or have other bloodborne pathogens (eg, hepatitis B or C).[112] Following the discussion below, this Paper concludes that health-care workers who observe these guidelines regarding universal precautions and practice modifications likely need not have any concerns about criminal liability as a result of the *Cuerrier* decision.

Proper adherence to universal precautions should more than suffice in almost all circumstances to sufficiently reduce the risk that it could and should no longer be considered (legally) "significant."

Universal precautions for all procedures

The data cited in the preceding section indicate that the risk of transmission is extremely low, even in the case of invasive procedures. Proper adherence to universal precautions should more than suffice in almost all circumstances to sufficiently reduce the risk that it could and should no longer be considered (legally) "significant." Therefore, pursuant to the analytical approach set out in *Cuerrier*, the criminal law should not impose any duty on the HIV-positive person to disclose their HIV-positive status before the procedure is conducted. This issue has not been litigated in Canada, and there is therefore no firm legal conclusion on this point to guide health-care workers. It is recommended to prosecutors and the judiciary that this conclusion be accepted in law should this issue be raised in future criminal proceedings.

"Exposure-prone procedures"

There remains an outstanding concern about that subset of invasive procedures that constitute "exposure-prone procedures." As the term indicates, such procedures pose a risk of transmitting bloodborne pathogens such as HIV. It is suggested here that legal guidance may be found in the language of the Canadian definition of "exposure-prone procedures." The "Consensus" Conference Proceedings use the term "significant risk of transmission" in defining "exposure-prone procedures" as:

> procedures during which transmission of HBV [hepatitis B virus], HCV [hepatitis C virus], or HIV from a [health-care worker] is *most likely to occur* and includes the following:
>
> a) digital palpitation of a needle tip in a body cavity (a hollow space within the body or one of its organs) or the simultaneous presence of the HCW's fingers and a needle or other sharp instrument or object in a blind or highly confined anatomic site, eg during major abdominal, cardiothoracic, vaginal and/or orthopedic operations, or

[112] See, inter alia: (1) College of Physicians and Surgeons of Alberta. HIV Infection in Health Care Workers (September 1992); (2) College of Physicians and Surgeons of Ontario. MDs Infected with HIV or HB (1994); Policy on Physicians Infected with Blood-Borne Pathogens (February 1994); (3) Manitoba College of Physicians and Surgeons. Communicable Diseases (Bloodborne) in Physicians (Including HIV and Hepatitis B) (No 123); Communicable Diseases (Bloodborne) in Physicians – Counselling (No 135); Bloodborne Pathogen Precautions (No 136).

> b) repair of major traumatic injuries, or
> c) major cutting, or removal of any oral or perioral tissue, including tooth structures
>
> during which blood from an injured HCW may be exposed to the patient's open tissues.
>
> It is recognized that it is difficult to determine every situation in which there is a *significant risk of transmission* of a bloodborne pathogen, and therefore this definition is meant to guide the practitioner and/or expert panel in making an informed decision about the factors in a specific case.[113]

The US CDC recommends that an HIV-positive health-care worker "should not perform exposure-prone procedures unless ... [s/he] notifies patients of the health care worker's seropositivity before they undergo exposure-prone procedures."[114] The most recent, Canada-wide statement of general principles is expressed in the Proceedings of the "Consensus"[115] Conference, which similarly concluded that disclosure of HIV-positive status by health-care workers is not required *if* they obtain and follow expert advice regarding refraining from "exposure-prone procedures." The Consensus Conference Proceedings state the following principles:

- mandatory HIV testing of health-care workers is not justified;
- full and proper compliance with universal precautions is adequate in most circumstances to reduce the risk of transmission to an acceptable level, and therefore actual disclosure of HIV-positive status by a health-care worker would not be required;
- any health-care worker with an infectious disease that could put a patient at risk should, as an ethical principle, seek medical evaluation by a primary-care physician, who should seek advice on assessing the risk of transmission in the health-care setting through a consultation mechanism that preserves the infected health-care worker's confidentiality;
- guidelines should establish criteria to be considered by the health-care worker and an expert panel in making an informed decision in the circumstances of a particular case about whether the worker should refrain from performing "exposure-prone procedures"; and
- provided the health-care worker follows the panel's recommendations, disclosure of the worker's status to patients is not required.[116]

While there is certainly a consensus as to the first two of these points, the issue of an "obligation to report" one's HIV-positive diagnosis is controversial. There is also ongoing debate over how broadly the category of "exposure-prone procedures" should be defined, and whether existing definitions unduly restrict the professional lives of HIV-positive health-care workers.[117] As one commentator argues:

> [R]eview of the evidence strongly suggests that the best way to protect the public is by strict adherence to universal precautions and the voluntary use of expert advisory panels on an anonymous basis. Mandatory reporting of the identities of HIV-positive physicians and the use of expert panels that have the authority to ban doctors

[113] Conference Proceedings, supra, note 97 at "Definitions." [emphasis added]

[114] Centers for Disease Control. Recommendations for preventing transmission of human immunodeficiency virus and hepatitis B virus to patients during exposure-prone procedures. *Morbidity and Mortality Weekly Report* 1991; 40: 1-9.

[115] The characterization of this conference as having reached a "consensus" is incorrect. See the responses from the Canadian Medical Association and the Canadian Dental Association appended to the conference proceedings. The AIDS Committee of Toronto and AIDS Action Now! have also expressed their opposition to the imposition of an obligation to "report to an expert panel" as being equivalent to mandatory reporting, and as unwarranted and unproductive: Jürgens, supra, note 6 at 193.

[116] See, for example: Laboratory Centre for Disease Control (Health Canada). Preventing the transmission of bloodborne pathogens in health care and public service settings. *Canada Communicable Disease Report* 1997; 23S3.

[117] For the "Canadian definition" of "exposure-prone procedures" defined by Health Canada's Laboratory Centre for Disease Control, see the Consensus Conference Proceedings, supra, note 97.

> from doing certain procedures would only lead to fewer doctors at risk of HIV infection coming forward for testing and treatment and to mandatory testing for all."[118]

The threshold for disclosure set out in the criminal law is consistent with the threshold already enunciated in professional standards.

In June 1998, the College of Physicians and Surgeons of Ontario approved a policy on bloodborne pathogens that did not mandate that physicians be tested and report for HIV and hepatitis B and C, and does not require physicians to disclose their serostatus to patients. However, the College does state that physicians have an ethical obligation to know their immunological status and take appropriate steps to prevent transmission to patients, including seeking confidential advice from an expert panel regarding necessary practice modifications.[119] There is some concern that imposing such a professional obligation amounts to a mandatory reporting requirement, which has been opposed by community-based AIDS organizations. However, mandating disclosure to patients has certainly been rejected as a policy option. As was noted in the Consensus Conference Proceedings:[120]

> If HCWs see disclosure as a threat to their livelihood they are less likely to want to know their serologic status or to seek testing voluntarily. If the expert panels make fully informed and valid decisions about the extent of the risk posed by infected HCWs who perform exposure-prone procedures and institute practice modifications or restrictions that the HCW follows, participants felt that disclosure would be unnecessary.[121]

HIV-positive health-care workers who follow existing, established professional guidelines regarding universal precautions and expert advice regarding "exposure-prone procedures" are unlikely to be exposed to criminal liability for non-disclosure of their HIV-positive status.

This Paper does not take up the debate over whether the actual content of the definition of "exposure-prone procedures" (ie, the specific procedures described) is overbroad. It suffices to conclude here that, regardless of the resolution of that debate, the criminal law threshold for disclosure set out in *Cuerrier* and the Health Canada guidelines are consistent. As recommended in the Consensus Conference Proceedings:

> Provided that the infected HCW's health status and the exposure-prone procedures have been assessed by the expert panel and all the panel's recommendations are followed, disclosure of a HCW's infected status to patients before an exposure-prone procedure is carried out is not required as a way of protecting patients from bloodborne pathogens.[122]

The *Cuerrier* decision imposing a duty to disclose HIV-positive status in some circumstances should not be taken as being at odds with these existing policies or guidelines. The Consensus Conference Proceedings specifically refer to a "significant risk of transmission of a bloodborne pathogen."[123] This obviously accords with the language used by the Court in *Cuerrier*; the threshold for disclosure set out in the criminal law is consistent with the threshold already enunciated in professional standards.

The debate over the precise procedures considered "exposure-prone" is not addressed here. Whichever procedures are ultimately included within the rubric of "exposure-prone," it suffices here to conclude that HIV-positive health-care workers who follow existing, established professional guidelines regarding universal precautions and expert advice regarding "exposure-prone procedures" are unlikely to be exposed to criminal liability for non-disclosure

[118] A Karrel. HIV-infected physicians: how best to protect the public? *Canadian Medical Association Journal* 1995; 152: 1059-1062.

[119] College of Physicians and Surgeons of Ontario. Policy on Blood Borne Pathogens. Toronto, June 1998.

[120] Consensus Conference Proceedings, supra, note 97.

[121] Ibid.

[122] Ibid.

[123] Ibid.

of their HIV-positive status. While this is not confirmed as a matter of law, it is a reasoned prediction for HIV-positive health-care workers, and is also a recommendation to prosecutors and the judiciary should they be called upon in some future case to consider the application of *Cuerrier* in the context of medical procedures.

Nor does the *Cuerrier* decision require professional regulatory bodies to revise their policies with a view to making them harsher or more restrictive vis-à-vis HIV-positive health-care workers. This language is the same as that of the *Cuerrier* decision, and existing policies and guidelines are directed at preventing exposure of patients to a "significant risk" of HIV transmission from health-care workers. A balance (albeit one that does not enjoy full consensus) has already been struck in the development of these policies and guidelines; *Cuerrier* does not upset that balance.

The *Cuerrier* decision does not require professional regulatory bodies to revise their policies with a view to making them harsher or more restrictive vis-à-vis HIV-positive health-care workers.

Non-disclosure of HIV status

Some questions have been raised as to how the *Cuerrier* decision regarding disclosure of HIV-positive status stands in relation to existing legal obligations on health-care workers to advise patients of the risks involved in medical procedures.

Existing tort law imposes *civil* liability on health-care professionals who fail to secure a patient's *informed consent*. That is, a health-care worker may be sued for damages in a civil suit alleging negligence by a patient who has suffered injury from a medical procedure if there was inadequate disclosure of the risks associated with that procedure. A civil lawsuit will only arise if there has been actual injury sustained by the patient as a result of the procedure and the risk of that injury was not disclosed to them in advance.

Court decisions in the area of tort liability for medical malpractice have established that informed consent cannot be given unless the patient is advised of "all material risks."[124] As stated by the Supreme Court of Canada in *Reibl*, a physician,

> generally, should answer any specific questions posed by the patient as to the risks involved and should, without being questioned, disclose to him the nature of the proposed operation, its gravity, any material risks or unusual risks attendant upon the performance of the proposed operation. However, having said that, it should be added that the scope of the duty of disclosure and whether or not it has been breached are matters which must be decided in relation to the circumstances of each particular case.... The Court in *Hopp* v *Lepp*, *supra* also pointed out that even if a risk is a *mere possibility* which ordinarily need not be disclosed, *yet if its occurrence carries serious consequences, as for example, paralysis or even death, it should be regarded as a material risk requiring disclosure*.[125]

Existing tort law therefore already establishes a threshold for disclosure for the HIV-positive health-care worker. Where a medical procedure carries a "mere possibility" of HIV transmission from health-care worker to patient, the law considers this a "material" risk that must be disclosed in order to ensure the patient's informed consent (*Reibl*, supra). In a subsequent case, the courts required full disclosure to the patient of an "infinitesimally small" risk of death.[126] As explained by one commentator:

[124] *Hopp* v *Lepp*, [1980] 2 SCR 192; *Reibl* v *Hughes*, [1980] 2 SCR 880; *Videto* v *Kennedy* (1981), 125 DLR (3d) 127 (Ont CA); *Haughian* v *Paine*, [1986] SJ No 352 (Sask QB) (QL); *Malette* v *Shulman* (1990), 37 OAC 281 (CA); *Fleming* v *Reid* (1991), 82 DLR (4th) 298 (Ont CA); *Lue* v *St Michael's Hospital*, [1997] OJ No 255 (Gen Div) (QL); *Halkyard* v *Mathew*, [1998] AJ No. 986 (QB) (QL); *Van Mol (Litigation Guardian of)* v *Ashmore*, [1999] BCJ No 31 (CA) (QL).

[125] *Reibl*, supra, note 124 at 884-885 [emphasis added].

[126] *Kitchen* v *McMullen* (1989), 62 DLR (4th) 481, 50 CCLT 213 (NBCA), leave to appeal to SCC refused, [1990] 1 SCR viii (contraction of hepatitis through blood transfusion).

> The trend that has been established in Canadian courts is a logical one: materiality of risk is derived from an inverse relationship between degree of severity and the likelihood of occurrence. Therefore while it is unlikely that the doctor is under an obligation to inform the patient of a 1 in 50,000 risk of developing a harmless rash, the doctor is much more likely to be required to inform that patient of a risk of death with the same likelihood of occurrence.[127]

Courts have indicated that professional standards, while not determinative of whether a risk is "material" and therefore needs to be disclosed, are an important factor to be considered in determining whether a health-care worker is civilly liable for negligence in not disclosing a known risk of injury to a patient.[128]

It must be remembered that this "mere possibility" threshold for disclosure is set out in tort law, which imposes *civil* liability. Obviously, most medical procedures will not carry any material risk of HIV transmission, and tort law would not impose any obligation on the HIV-positive health-care worker to disclose. As noted, to date only two cases have documented HIV transmission from health-care worker to patient via medical procedures.

The *Cuerrier* case considered the issue of whether non-disclosure could result in *criminal* liability. Tort law and criminal law are distinct. As a general rule, the law requires a higher degree of wrongdoing and a higher standard of proof before imposing criminal sanctions. Not surprisingly, the threshold for disclosure set out in the criminal law by *Cuerrier* ("significant risk") is higher than the threshold for disclosure already set out in tort law ("mere possibility"). The *Cuerrier* judgment does not, therefore, extend the duty of disclosure of the HIV-positive health-care worker.

What it does mean, however, is that where a procedure carries a "significant risk" of transmission, the health-care worker may be held *criminally* liable for not disclosing their HIV-positive status to a patient. (If the patient were infected as a result of the medical procedure, presumably the health-care worker could be held civilly liable as well: obviously a risk of HIV transmission that could be considered "significant" would also meet the lower threshold of being considered "material.") But the "mere possibility" of HIV transmission during a medical procedure, while sufficient to ground civil liability on the part of the health-care worker, should not be considered to meet the threshold of a "significant risk" for the purposes of the criminal law as stated in *Cuerrier*; the health-care worker should not be subject to a criminal prosecution for assault for not disclosing their HIV-positive status when there is only a "mere possibility" of transmission.

Recommendation

Recommendation 12

> *The* Cuerrier *decision should not be interpreted as imposing criminal liability on an HIV-positive health-care worker for not disclosing their HIV-positive status, if they have followed established professional guidelines regarding universal precautions and expert advice regarding "exposure-prone procedures."*

[127] JC Wright, JL Allinson. AIDS, mandatory testing and serostatus disclosure in the health care setting. *Health Law Review* 1994; 3(2): 13-24 at 17.

[128] *Videto* v *Kennedy*, supra, note 124 at 133.

Public Health Law, Policy, and Practice

The *Cuerrier* decision indicates that it may be a criminal assault under Canadian law for an HIV-positive person not to disclose their serostatus under circumstances where their conduct poses a "significant risk" of transmission. The primary purpose of this paper is to analyze what the decision may mean regarding possible criminal liability of HIV-positive people in various circumstances.

However, the *Cuerrier* case has also prompted some to ask whether the decision affects public health practice. This chapter considers whether *Cuerrier* requires any change in public health practice or the exercise of powers and obligations under public health legislation, such as pre- and post-test counseling, partner notification, and public health interventions.

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Counseling and Partner Notification

Existing principles not changed

"Partner notification" is "the spectrum of public health activities in which sexual and injection equipment–sharing partners of individuals with HIV infection are notified, counseled about their exposure, and offered services."[129] As noted by Jürgens: "The controversial question that remains to be addressed is *not about whether* sex partners or needle-sharing partners should be informed that they may be HIV-infected, *but about how* this notification should be achieved."[130]

[129] World Health Organization. Consensus statement consultation on partner notification for preventing HIV transmission. *Venereology* 1990; 3(1):17, cited in Jürgens, supra, note 6 at 239.

[130] Jürgens, supra, note 6 at 239, citing D Roy (ed). HIV Infection and AIDS, Ethical-Legal Issues 1991, A Report. Montréal: Centre québécois de coordination sur le sida, 1991, at 56.

The January 1997 *Guidelines for Practice for Partner Notification in HIV/AIDS* prepared by the Federal/Provincial/Territorial Advisory Committee on AIDS (Working Group on Partner Notification) state that partner notification is acceptable only if it adheres to certain principles. According to the Guidelines, partner notification should, among other things:

- be voluntary, non-coercive, and non-prejudicial;
- maintain strict confidentiality for all information concerning both the index person and the partners, including written records, locating information for partners and, when the health worker does the notification, the identity of the index person;
- ensure that during the notification process, when partners are told of the possibility of HIV exposure, no additional information is given that may identify the index person;
- attempt to ensure that index persons and their partners have adequate social support systems.[131]

The *Cuerrier* judgment has determined that an HIV-positive person may commit a criminal assault if they do not disclose their serostatus before exposing another person to a significant risk of infection. *Cuerrier* affects the relationship between an HIV-positive person and others to whom their conduct may pose a "significant risk" of transmission. This does not change current obligations with respect to partner notification, nor is it at odds with the principles that should guide partner notification schemes.

Incorporating *Cuerrier* into counseling

The F/P/T Advisory Committee also stated a number of program issues that must be taken into account in designing partner notification programs:

- Each person who requests HIV testing and counseling should understand the partner notification program in his/her jurisdiction and its implications before testing proceeds.
- The personal safety of a person who tests HIV-positive, as well as that of their partners and health workers, must be a high priority and should be assessed before notification proceeds.
- The involved communities must participate from the outset in the discussions and the decision-making process relating to partner notification (including HIV-positive people and community-based AIDS organizations).
- Certain exposures may be judged not *significant* and thus not require partner notification. Safer-sex guidelines that address the significance of various exposures are available. For instance, the Canadian AIDS Society has published a document on safer sex that was the result of a broad consultative process.
- Programs should be capable of dealing with HIV-positive individuals who are unwilling to cooperate with the notification of partners, although this will occur infrequently. Many jurisdictions and several medical associations permit the notification of current partners without the consent but with the knowledge of an uncooperative person who has tested HIV-positive, in order to prevent future infection of those still at risk. Public health should

[131] *Guidelines for Practice for Partner Notification in HIV/AIDS*, supra, note 60.

work with the involved communities to generate creative solutions to these difficult situations.[132]

The F/P/T Advisory Committee requires that pre- and post-test counseling ensure that people understand the partner notification program to be implemented if they test positive. For example, current HIV counseling guidelines produced by the Canadian Medical Association, which reflect principles widely accepted as a standard of practice for physicians, currently state:

> During a pretest counselling session, patients should be informed that, if the test result is positive, the physician is ethically obliged to ensure that sexual and drug-use partners are made aware that they may have been exposed to HIV. If an HIV-positive patient refuses or is unable to inform his or her partners, the possibility that either the physician or a public health professional will notify partners should be discussed with the patient before such disclosure occurs.[133]

The *Cuerrier* decision confirms the possibility of criminal prosecution for non-disclosure of HIV-positive status in some circumstances. It is therefore important that pre- and post-test counseling include not only an explanation of partner notification, but also ensure that people testing HIV-positive are aware of the possibility of criminal prosecution if they do not disclose their status before engaging in activities posing a "significant" risk of transmission.

It is therefore important that pre- and post-test counseling include not only an explanation of partner notification, but also ensure that people testing HIV-positive are aware of the possibility of criminal prosecution if they do not disclose their status before engaging in activities posing a "significant" risk of transmission.

Communicating information about the risk of criminal prosecution for non-disclosure before unprotected sex and sharing injection equipment likely reinforces the stigma and punitive approach already surrounding HIV testing and a positive diagnosis. It must be handled sensitively. The possible adverse consequences of disclosure to partners (as noted above) highlights the need to consider personal safety and social support in approaching the task of partner notification. This is recognized in the F/P/T Advisory Committee Guidelines, but the lack of any express recognition in the *Cuerrier* decision as to the legal significance of these risks presents an additional difficulty for a person with HIV/AIDS in approaching disclosure to a partner.

Policy and practice must be accurate and consistent with *Cuerrier*

In responding to the *Cuerrier* decision, public health officials and front-line workers must ensure that the information provided through counseling regarding the duty to disclose HIV-positive status is accurate. There is some cause for concern in this regard. For example, the interpretation of *Cuerrier* provided to all medical officers of health in Ontario overstates the Court's decision. A memorandum from the Ministry of Health and the Chief Medical Officer of Health is of concern in that:

- The memorandum states that, according to *Cuerrier*, fraud that invalidates consent must include "the risk of serious harm." It does not relay that the Court made a point of expressly stating that a *significant* risk of serious harm is required for criminal liability – the crux of the decision.
- The memorandum highlights the instruction that "comprehensive counselling must also include partner notification and the need for individuals to

In responding to the *Cuerrier* decision, public health officials and front-line workers must ensure that the information provided through counseling regarding the duty to disclose HIV-positive status is accurate.

[132] Ibid. [emphasis added]

[133] Canadian Medical Association. *Counselling Guidelines for HIV Testing*. Ottawa: The Association, 1995, at 7.

disclose and not to lie about their HIV status to *all* sexual partners." Again, this overstates the duty of disclosure enunciated by the Court, which indicated that the duty to disclose HIV status only arises if there is a "significant risk of serious bodily harm." The decision does *not* require disclosure to sexual partners where there is no "significant risk" of HIV transmission.[134]

Recommendations

Recommendation 13

Physicians or public health workers conducting partner notification must still ensure that all a person's circumstances (including concern about safety) are taken in account in determining when and how to notify partners of their possible exposure to HIV infection. The decision in Cuerrier *imposing a duty to disclose on an HIV-positive person before engaging in activities posing a "significant risk" of transmission should not mean that public health workers derogate from this guideline and practice.*

The effect of *Cuerrier* is to highlight the need for ensuring that public health interventions are used appropriately before criminal sanctions are invoked.

Recommendation 14

Public health officials and front-line workers, and health-care workers responsible for providing pre- and post-test counseling and who engage in partner notification, must incorporate into their counseling practice the provision of accurate information about when the criminal law may impose a duty to disclose HIV-positive status, such that not disclosing in those circumstances may give rise to criminal liability.

Recommendation 15

Access to anonymous (or at least flexible non-nominal) testing needs to be improved, in order to counteract any detrimental effect on testing that may flow from the knowledge that not disclosing HIV-positive status may result in criminal prosecution.

Recommendation 16

Research is required into the effects of coercive public health approaches and the use of criminal sanctions for non-disclosure on people's willingness to get tested for HIV infection and to access care and support services, particularly among those at higher risk of infection.

Coercive Public Health Interventions

As has been noted, the *Cuerrier* decision and its imposition of a duty to disclose HIV-positive status in limited circumstances affects the relationship between a person with HIV/AIDS and those with whom they engage in conduct carrying a "significant" risk of transmission. It does not impose any additional legal obligation on those responsible for implementing public health legislation or policy, nor does it alter existing obligations under said legislation or policy to take steps to protect the public health.

The effect of *Cuerrier* is to highlight the need for ensuring that public health interventions are used appropriately before criminal sanctions are invoked. Consideration has been given in several provinces to developing responses to

[134] Ontario Ministry of Health. Memorandum to All Medical Officers of Health from Chief Medical Officer of Health and Legal Services Branch, 5 February 1999.

be implemented in those circumstances where an HIV-positive person continues to engage in activity that risks HIV transmission without disclosing their status to those placed at risk (eg, sexual partners and those sharing injection equipment).[135] As is generally reflected in existing guidelines (eg, City of Toronto Department of Public Health) or expressly recommended by entities such as the Ontario Advisory Committee on HIV/AIDS or the Montréal General Hospital working group, the principle of adopting the "least intrusive, most effective" intervention is generally accepted as guiding public health practice.

Such an approach is also consistent with the 1996 UN International Guidelines on HIV/AIDS and Human Rights, which provide:

> Guideline 3: Public health legislation
>
> (d)... Where the liberty of persons living with HIV is restricted due to their illegal behaviour, due process protections (eg, notice, rights of review/appeal, fixed rather than indeterminate periods of orders and rights of representation) should be guaranteed….
>
> (g) Public health legislation should authorize, but not require, that health care professionals decide, on the basis of each individual case and ethical considerations, to inform their patients' sexual partners of the HIV status of their patient. Such a decision should only be made in accordance with the following criteria:
>
> The HIV-positive person in question has been thoroughly counselled.
>
> Counselling of the HIV-positive person has failed to achieve appropriate behavioural changes.
>
> The HIV-positive person has refused to notify, or consent to the notification of his/her partner(s).
>
> A real risk of HIV transmission to the partner(s) exists.
>
> The HIV-positive person is given reasonable advance notice.
>
> The identity of the HIV-positive person is concealed from the partner(s), if this is practically possible; Follow-up is provided to ensure support to those involved, as necessary.

Criminal sanctions should be a measure of last resort, to be implemented only once the more flexible interventions available to public health officials have been unsuccessful in effecting the necessary behaviour change.

In line with this approach, criminal sanctions should be a measure of last resort, to be implemented only once the more flexible interventions available to public health officials have been unsuccessful in effecting the necessary behaviour change. Indeed, as noted above, the Guidelines also specifically recommend that States ensure their criminal laws "are not misused in the context of HIV/AIDS."[136]

However, as criminal charges ultimately remain an option, regard should be had for the standard of behaviour regarding HIV disclosure set out in the criminal law (to the extent that this can currently be determined). *Cuerrier* imposes a duty on the HIV-positive person to disclose if their conduct poses a *significant* risk of transmission. Therefore, if public health interventions bring about

[135] Hôpital général de Montréal (Module prévention et contrôle des MTS/SIDA). Politique d'intervention envers les personnes séropositives qui ne prennent pas les précautions nécessaires pour prévenir la transmission du VIH. (Document de travail). Montréal: 4 juillet 1996; Manitoba Health. Guidelines for Reducing HIV Transmission by People Who Are Unwilling or Unable to Take Appropriate Precautions. Winnipeg: 13 April 1996; Office of the [British Columbia] Provincial Health Officer. Public Health Guidelines for Managing Difficult HIV Cases. Victoria: November 1993; Ontario Advisory Commitee on HIV/AIDS. "Reducing HIV Transmission by People with HIV Who Are Unwilling or Unable to Take Appropriate Precautions. Toronto: September 1997.

[136] Guidelines on HIV/AIDS and Human Rights, supra, note 45.

behaviour change such that there are no reasonable and probable grounds to believe an HIV-positive person is engaging in conduct posing a *significant* risk of transmission, then there is no basis for resorting to the criminal justice system.

Recommendations

Recommendation 17

> *Public health departments and officials should ensure their policy and practice with respect to interventions vis-à-vis individuals who place others at significant risk of infection provides for a graduated response, guided by the principle of "least intrusive, most effective" practice. Experiences and best practice models regarding such interventions should be shared among health units within and between provinces.*

Recommendation 18

> *Prosecutors should consult with public health authorities before laying or pursuing criminal charges, to determine whether measures under public health legislation offer an alternative to prosecution.*

Recommendation 19

> *If necessary, legislation, regulation, and policies should be amended to ensure adequate procedural safeguards (eg, automatic review of orders, rights to appeal and to representation by counsel) against the misuse of coercive public health powers.*

Disclosure of Confidential Information Compelled by Law

In this chapter, the Paper considers three circumstances in which disclosure of information about a person's HIV status or conduct vis-à-vis others is or may be compelled by law:

- HIV/AIDS reporting obligations pursuant to public health law;
- a common law "duty to warn" a person at risk of infection from the conduct of an HIV-positive person; and
- compliance with a search warrant or subpoena in a criminal prosecution.

The Paper concludes that *Cuerrier* does not have the effect of changing the existing legal duties in these areas – and should not be interpreted as having any such effect. It concludes, however, that community-based organizations serving people with HIV/AIDS may wish to develop policies or protocols for dealing with confidential information about people's HIV status or risk activities.

Reporting HIV/AIDS

The legal requirements for reporting HIV and AIDS are matters dealt with by provincial/ territorial public health legislation. As reported in *HIV Testing and Confidentiality: Final Report*,[137] every province and territory requires the reporting to public health authorities of any diagnosis of AIDS. In addition, all

[137] Jürgens, supra, note 6 at 231.

provinces and territories require the reporting of an HIV diagnosis, except for Québec, British Columbia, and Yukon.[138] (It is expected that 1998 recommendations to make HIV seropositivity non-nominally reportable in Québec will be accepted. In BC, non-nominal collection of data regarding HIV diagnoses is done by testing laboratories.) In some jurisdictions, HIV and AIDS are reportable by name; in others they are reported non-nominally.

Public health legislation also identifies categories of persons upon whom the defined reporting obligations fall. In all provinces, physicians and laboratories are mandated to report; in some provinces, statutory reporting obligations are also imposed on additional categories of people such as teachers, school principals, and prison directors. Mandatory reporting obligations (at least insofar as imposed upon laboratories) have been upheld as constitutionally permissible infringements of the privacy rights of those tested.[139]

The *Cuerrier* case has no bearing on statutory reporting obligations on physicians, testing laboratories, or others named in the applicable provincial statutes.

Some have questioned whether the *Cuerrier* decision affects the reporting obligations established under public health legislation. The *Cuerrier* case dealt with the question whether an HIV-positive person could legally be convicted of assault for engaging in unprotected sex without disclosing their positive serostatus. This has no bearing on statutory reporting obligations on physicians, testing laboratories, or others named in the applicable provincial statutes.

The "Duty to Warn"

The common law has long recognized that health-care professionals owe a duty of confidentiality to their patients, subject to some exceptions.[140] In some provinces, the duty of confidentiality is also imposed by statute. Furthermore, it is professional misconduct for a health professional to disclose information about a patient to another person without the patient's consent except "as required or allowed by law."[141] However, professional bodies, legislatures, and courts have recognized that, in some circumstances, confidentiality must give way in order to protect other interests – including the protection of third parties.

For example, the Canadian Medical Association advises physicians that disclosure to a spouse or current sexual partner may not be unethical and may indeed be indicated when physicians are confronted with a patient who is unwilling to inform the person at risk. Such disclosure may be justified when all the following conditions are met: the partner is at risk of infection with HIV and has no other reasonable means of knowing of the risk; the patient has refused to inform their sexual partner; the patient has refused an offer of assistance by the physician to do so on the patient's behalf; and the physician has informed the patient of the physician's intention to disclose the information to the partner.[142] According to the CMA Counselling Guidelines, before breaching confidentiality, the physician should intervene to motivate the patient to either disclose or stop unsafe behaviours, through counseling and discussion of possible barriers to risk reduction. However, if such interventions ultimately fail, the physician is advised by the CMA to report the situation to public health authorities.[143] The Canadian Association of Social Workers offers similar advice.[144]

Obligations to breach confidentiality may also be imposed by statute. As noted by Casswell, two jurisdictions (Yukon Territory and Prince Edward Island) have legislation that requires or permits physicians to disclose

[138] See the bibliography for references to the applicable public health statutes and regulations relevant to HIV/AIDS.

[139] *Canadian AIDS Society* v *Ontario* (1995), 25 OR (3d) 388 (Gen Div), aff'd (1996), 39 CRR (2d) 236 (CA).

[140] *Halls* v *Mitchell*, [1928] SCR 125, [1928] 2 DLR 97; *Re Inquiry into the Confidentiality of Health Records in Ontario* (1979), 24 OR (2d) 545, 98 DLR (3d) 704 (CA); *R* v *Dersch*, [1993] 3 SCR 768; *McInerney* v *MacDonald* (1992), 93 DLR (4th) 415.

[141] *St Louis (Litigation Guardian of)* v *Feleki* (1990), 75 DLR (4th) 758 (Ont Ct Gen Div), aff'd on other grounds (1993), 107 DLR (4th) 767 (Ont Div Ct); *Shulman* v *College of Physicians and Surgeons (Ontario)* (1980), 29 OR (2d) 40 (Div Ct).

[142] Canadian Medical Assocation. Acquired immunodeficiency syndrome: A CMA Position. *Canadian Medical Association Journal 1989; 140 (reprinted in Health Law Review* 1994; 3(2): 25-26).

[143] *Counselling Guidelines for HIV Testing*, supra, note 133 at 19.

[144] Canadian Association of Social Workers. *Comprehensive Guide for the Care of Persons with HIV Disease* (Module 6: Psychosocial Care). Ottawa: The Association, 1997.

confidential information without a patient's consent if doing so is necessary to protect a third party.[145] In all other jurisdictions, the physician must be guided by existing legislation regarding medical confidentiality and by any common law regarding confidentiality (and permitted or obligatory breaches of confidentiality).

In the wake of *Cuerrier*, some have raised the issue of whether the decision affects any common law "duty to warn" that may fall upon some categories of helping professionals – that is, a duty to breach confidentiality (eg, about a person's HIV-positive status) in order to protect the health and well-being of another person (eg, someone exposed to the risk of HIV infection by that person).

Cuerrier should not be taken as affecting any common law "duty to warn."

Cuerrier addresses the question of whether an HIV-positive person may be criminally liable for not disclosing their status before engaging in activity that risks transmitting the virus to another. It is not a case about whether the physician or counselor of an HIV-positive person is civilly liable for negligence if they become aware that the person they are counseling is engaging in activity posing a "significant" risk of transmission without disclosing and they do not take adequate steps (including breaching confidentiality) to try to protect the health of the person's identifiable partner. It should be remembered that, where it exists, the duty is civil in nature, not criminal: where a person is found to be *negligent* for not discharging the duty, they may be liable to pay financial compensation to the person who was injured, but there is no criminal penalty. *Cuerrier* should not be taken as affecting any common law "duty to warn."

This issue of a "duty to warn" is a matter of some community debate, and it remains to be seen whether courts would hold a community-based organization (such as an AIDS service organization) subject to this duty to warn. It should also be remembered that the community debate will not be determinative of legal obligations; courts will ultimately be called upon to decide the extent and nature of a "duty to warn" under tort law. Courts' assessments of liability for failing to warn are fundamentally public policy choices, balancing the interest in preventing harm to someone identified as being at risk against the interest in protecting the confidential character of relationships where that confidentiality may be crucial to fostering the relationship.

Hospitals,[146] psychiatrists,[147] social workers,[148] and police[149] have all been found, in some circumstances, to have a duty to warn someone they can identify as being at risk of harm, which can extend so far as to revealing information that there is a competing interest in keeping confidential. The Supreme Court of Canada has also recently indicated that a danger to public safety could be a sufficiently compelling public interest to justify setting aside the confidentiality of lawyer–client communications ("solicitor–client privilege"), which has always been the privilege accorded the most deference by the courts. The Court has said that, in deciding whether public safety outweighs protecting confidential relationships, three factors must be considered:

- Is there a clear risk to an identifiable person or group of persons?
- Is there a risk of serious bodily harm or death?
- Is the danger imminent?

Future litigation may indicate how far a duty to warn may be extended, and whether a community group (or, more likely, a counselor affiliated with such a

[145] DG Casswell. Disclosure by a physician of AIDS-related patient information: an ethical and legal dilemma. *Canadian Bar Review* 1989; 68: 225 at 231, 256 (table B).

[146] *Wenden* v *Trikha* (1991), 8 CCLT (2d) 138 (Alta QB), aff'd (1993), 14 CCLT (2d) 225 (Alta CA).

[147] *Tarasoff* v *Regents of the University of California*, 131 Cal Rptr 14, 551 P. 2d 334 (1976); *Tanner* v *Norys*, [1980] 4 WWR 33 (Alta CA).

[148] *D(B)* v *British Columbia* (1995), 12 BCLR (3d) 306, [1996] 1 WWR 581 (SC).

[149] *Doe* v *Metro Toronto (Municipality) Commissioners of Police* (1998), 39 OR (3d) 487 (Gen Div).

group) would be treated similarly. Community-based organizations providing services and support to people with HIV/AIDS may wish to consider obtaining advice about their possible obligations in this area, and perhaps preparing some policies to give direction to their staff (eg, counselors) who are privy to information that raises a difficult ethical and legal question.

Evidence for Criminal Prosecutions

How can the integrity and utility of the counseling or other support relationship be maintained if a counselor may be compelled to reveal, under oath in a criminal proceeding, that an HIV-positive person they have counseled has engaged in unprotected sex without informing their partners?

In pursuing criminal prosecutions against HIV-positive people for risky conduct, prosecutors have obviously required and obtained evidence establishing the accused's HIV-positive status and the actions that are alleged to have either transmitted HIV or exposed another person to the risk of infection. For example, evidence from public health nurses regarding the accused's HIV test results and their counseling discussions with him were before the Court in *Cuerrier*.

Such prosecutions therefore raise the legal question of whether an HIV-positive person is entitled to prevent disclosure of certain kinds of information that would constitute evidence of their serostatus and/or conduct that risks transmission of HIV – such as patient records, counselor's notes, or research data – on the ground that their interest in confidentiality outweighs the prosecution's interest in obtaining evidence establishing their guilt.

Such prosecutions also raise practical questions: What information disclosed in a relationship that most think is confidential may end up being disclosed? How can the integrity and utility of the counseling or other support relationship be maintained if a counselor may be compelled to reveal, under oath in a criminal proceeding, that an HIV-positive person they have counseled has engaged in unprotected sex without informing their partners? And what should be done if prosecutors seek to compel disclosure of information obtained from the HIV-positive person through that confidential relationship?

Someone with information about a person's HIV-positive status or risky conduct may be compelled to disclose that information by either a search warrant executed by police, or a subpoena to appear and testify under oath in a criminal proceeding.

Search warrants and subpoenas

Someone with information about a person's HIV-positive status or risky conduct may be compelled to disclose that information by either a search warrant executed by police, or a subpoena to appear and testify under oath in a criminal proceeding. In order to get a search warrant, police must establish that there are "reasonable grounds" to believe the search will reveal evidence of the commission of a crime.[150] A court may issue a subpoena ordering a person to appear and testify in a criminal proceeding where that person "is likely to give material evidence,"[151] and may order that the person bring with them anything in their possession or control relating to the proceeding.[152] A person who does not appear, in compliance with the subpoena, may be arrested and brought to court to testify.[153] A person who refuses to testify is in contempt of court and may be fined and/or imprisoned.[154]

Constitutional right to privacy

Section 8 of the *Canadian Charter of Rights and Freedoms*[155] provides that everyone has the right to be secure against "unreasonable search or seizure." Courts have recognized a right to privacy under both this section and section 7 of the Charter, which includes a right to privacy in relation to information

[150] *Criminal Code*, supra, note 8 at s 487.

[151] Ibid at s 698(1).

[152] Ibid at s 700(1).

[153] Ibid at ss 698(2)-(3), 705.

[154] Ibid at ss 706-708.

[155] Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

about oneself.[156] However, as stated by the Supreme Court of Canada in the leading case of *Hunter* v *Southam*:

> The guarantee of security from *unreasonable* search and seizure protects only a *reasonable* expectation of privacy. This limitation on the right guaranteed by s. 8, whether it is expressed negatively, as freedom from "unreasonable" search and seizure, or positively, as an entitlement to a "reasonable" expectation of privacy, indicates that an assessment must be made as to whether in a particular situation the public's interest in being left alone by government must give way to the government's interest in intruding on the individual's privacy in order to advance its goals, notably those of law enforcement.[157]

When deciding whether confidential information should be disclosed to prosecutors, the courts weigh privacy interests against effective law enforcement. The Supreme Court has indicated that the following factors are to be considered in this balancing:

- the nature of the information itself;
- the nature of the relationship between the party releasing the information and the party claiming its confidentiality;
- the place where the information was obtained;
- the manner in which it was obtained; and
- the seriousness of the crime being investigated.[158]

Compelling disclosure of counseling records

Canadian courts have consistently refused to recognize an automatic privilege at common law for any confidential communications between a health-care professional and patient.[159] There has been some recognition of a privilege that may protect communications to a psychiatrist or a marriage counselor.[160] The Supreme Court and appellate court decisions have ruled that there is no judicial discretion to exclude otherwise relevant and admissible evidence simply because that information is confidential.[161] Rather, the Supreme Court has affirmed the following four principles as setting out a general framework for determining whether a given communication is privileged:

(1) The communication must originate in *confidence* that it will not be disclosed.
(2) This element of *confidentiality must be essential* to the full and satisfactory maintenance of the relation between the parties.
(3) The *relation* must be one that in the opinion of the community ought to be sedulously *fostered*.
(4) The *injury* that would inure to the relation by the disclosure of the communication must be *greater than the benefit* thereby gained for the correct disposal of litigation.[162]

It is evident that public policy considerations drive decisions about whether or not privilege should be extended to protect the confidentiality of communications made in the context of any given relationship. In one Ontario case, a trial judge exercised his discretion to not require a doctor to give evidence

[156] *R* v *Dyment*, [1988] 2 SCR 417, 45 CCC (3d) 244; *R* v *Plant*, [1993] 3 SCR 281, 84 CCC (3d) 203 *R* v *Spidell* (1996), 107 CCC (3d) 348 (NSCA).

[157] *Hunter* v *Southam*, [1984] 2 SCR 145, 41 CR (3d) 97.

[158] *R* v *Plant*, [1993] 3 SCR 281, (1993) 84 CCC (3d) 203 at 212.

[159] *Duchess of Kingston's Case* (1776), 20 How St Tr 355; *Halls* v *Mitchell*, supra, note 140; *D* v *National Society for the Prevention of Cruelty to Children*, [1978] AC 171, [1977] 1 All ER 589 (HL); *F* v *A Psychiatrist* (1984), 54 BCLR 319 (SC); *Upham* v *You* (1986), 73 NSR (2d) 73, 11 CPC (2d) 83 (CA), leave to appeal to SCC refused (1986), 76 NSR (2d) 180.

[160] *Dembie* v *Dembie* (1963), 21 RFL 46 (Ont SC); *G* v *G*, [1964] 1 OR 361 (HCJ); *Shakotko* v *Shakotko* (1976), 27 RFL 1 (Ont Supr Ct); *Porter* v *Porter* (1983), 40 OR (2d) 417; *Torok* v *Torok* (1983), 44 OR (2d) 118, 38 CPC 52 (Master).

[161] *R* v *Hawke* (1975), 7 OR (2d) 145, 22 CCC (2d) 19 (CA) at 181 OR; *R* v *Wray* (1970), 4 CCC 1, 11 DLR (3d) 673 (SCC); *Reference re Legislative Privilege* (1978), 39 CCC (2d) 226 (Ont CA).

[162] *Slavutych* v *Baker*, [1976] 1 SCR 254; *R* v *Gruenke*, [1991] 3 SCR 263. For a discussion see: J Sopinka, SN Lederman, AW Bryant. *The Law of Evidence in Canada*. Markham: Butterworths, 1992, at 629.

concerning one of the litigant's venereal diseases, on the basis that such disclosure would be contrary to the public interest underlying the public health legislation in question (since repealed), which was to encourage those with venereal disease to seek treatment.[163]

However, it is questionable whether this decision would be followed or applied today in light of other developments indicating courts' unwillingness to recognize physician–patient privilege.

In a case already noted above, the Supreme Court has ruled that even the strongest form of privilege, that between a lawyer and client, is subject to a "public safety exception."[164] The Court has thus confirmed that the confidentiality of such a relationship may be breached in the interests of protecting public safety where there is a clear, imminent risk of serious bodily harm or death. Furthermore, Ontario's public health statute (as currently enacted) permits the disclosure of information regarding persons and their communicable disease "for the purposes of public health administration" or in connection with proceedings under numerous statutes, including the *Criminal Code*.[165]

Québec is the only province that extends privilege by legislation to the general physician–patient relationship.[166] However, this duty of "professional secrecy" set out in Québec civil law or the Québec *Charter of Human Rights and Freedoms* does not apply to criminal proceedings; in Canada, criminal law is a matter of federal jurisdiction, and federal criminal law does not recognize a physician–patient privilege.[167]

The Supreme Court has effectively approved disclosure of information obtained from an accused in a counseling context. In *R* v *RJS,*[168] the accused was charged with sexual offences involving alleged sexual abuse of his stepdaughters. He was referred to a family clinic for counseling sessions, and the Crown sought to introduce a tape recording of one of the sessions that had been made by the clinic. The Ontario Court of Appeal ruled that the evidence was to be admitted because, even though there was a therapeutic psychiatric relationship, the group session was confidential and group therapy for family counseling purposes should be encouraged, the injury to the relationship from compelling disclosure being outweighed by the benefit gained by the correct disposal of the litigation, since the search for truth in the criminal process outweighed the need for family counseling (at least in cases of suspected child abuse). The Supreme Court denied leave to appeal.

Community-Based Organizations: A Need for Policy

Community-based organizations, or staff working in such organizations, may find themselves confronting a legal obligation to breach confidentiality. They could conceivably face civil liability if they fail to discharge a common law "duty to warn" someone at risk of HIV infection, although this question remains unsettled in Canadian law. Or a search warrant or subpoena may be issued ordering the disclosure of confidential information for use in a criminal prosecution.

The response of AIDS service organizations and other community-based organizations to such legal obligations will likely vary. Some organizations may feel strongly that breaching confidentiality will undermine the trust relationship with the community they serve, ultimately damaging their efforts to prevent HIV transmission and to provide care, treatment, and support for

163 *Carter* v *Carter* (1974), 6 OR (2d) 603 (HC).

164 *John Smith* v *James Jones*, supra, note 30.

165 *Health Protection and Promotion Act*, RSO 1990, c H.7, s 39(2).

166 *Medical Act*, RSQ 1977, c M-9, s 42; Québec *Charter of Human Rights and Freedoms*, RSQ, c C-12, s 9.

167 *R* v *Potvin* (1971), 16 CRNS 233 (Que CA).

168 (1985), 19 CCC (3d) 115 (*sub nom R* v *RS*), 45 CR (3d) 161, 8 OAC 241, leave to appeal to SCC refused (1985), 61 NR 266n.

people with HIV/AIDS. As a preventive measure, such organizations might seek to avoid having the obligation to breach confidentiality arise. Some might refuse to breach confidentiality even if the face of an obligation to do so, and risk the legal consequences.

Whatever the response, if they have not already done so, AIDS service organizations and other community-based organizations serving HIV-positive people may wish to consider developing policies and guidelines (especially for counseling staff and volunteers) for dealing with confidential information about a person's HIV status or risk activities, and the disclosure of that information. Each organization will have to develop its own policies (the content of which may depend in part upon political considerations within the organization). However, the following points might be kept in mind:

- Counselors should advise those to whom they provide support services that disclosure of certain information (eg, engaging in conduct that risks transmitting HIV without disclosing serostatus) is not protected by absolute confidentiality. The counselor could be compelled to reveal that information in a criminal prosecution against the person, pursuant to a court order. The counselor *might* also risk civil liability if they do not breach confidentiality in some circumstances to warn a person at risk of infection, if the person being counseled has not disclosed their status to them.
- An organization could insist on following a procedure similar to that set out for lawyers in the *Criminal Code*: assert privilege when presented with a search warrant,[169] insist that police seal the records in question, and seek a judicial ruling as to whether the document should be disclosed.[170]
- Shredding records is "manifestly inappropriate,"[171] and those who destroy records after being served with a subpoena may be cited for contempt of court and subject to a fine and/or imprisonment.
- Legal advice should be sought in the preparation of such policies, and protocols could provide for obtaining legal advice in individual situations where legal obligations regarding disclosure are unclear.

AIDS service organizations and other community-based organizations serving HIV-positive people may wish to consider developing policies and guidelines for dealing with confidential information about a person's HIV status or risk activities, and the disclosure of that information.

Counselors should advise those to whom they provide support services that disclosure of certain information (eg, engaging in conduct that risks transmitting HIV without disclosing serostatus) is not protected by absolute confidentiality.

Recommendation

Recommendation 20

> *AIDS service organizations and other community-based organizations should consider developing policies or protocols for the guidance of staff (and possibly volunteers) who may or do come into possession of information about conduct by an HIV-positive person who risks transmitting the virus. Such policies should address the development and parameters of a counseling relationship, possible professional and legal obligations on counselors to breach confidentiality in some circumstances, and how to respond to requests by police or prosecution for disclosure of confidential counseling records.*

[169] *Presswood* v *International Chemalloy Corp* (1975), 65 DLR (3d) 228, 11 OR (2d) 164 (HCJ); *Solosky* v *Canada*, [1980] 1 SCR 821, 105 DLR (3d) 745; *Descôteaux* v *Mierzwinski*, [1982] 1 SCR 860, 70 CCC (2d) 385; Sopinka, Lederman & Bryant, supra, note 162 at 646-647.

[170] *Criminal Code*, supra, note 8 at s 488.1.

[171] *R* v *Carosella* (1995), 44 CR (4th) 266, 102 CCC (3d) 28 (Ont CA), rev'd on other grounds (1997), 112 CCC (3d) 289 (SCC).

Conclusion

The Supreme Court's judgment in *Cuerrier* itself offers a caution against an overly broad interpretation of the decision and an overly eager resort to the criminal law in light of the complexity of the issues raised by such cases.

As stated at the outset, the purpose of this Paper has been twofold. First, it has attempted to provide people with HIV/AIDS and others a clearer understanding of what the *Cuerrier* decision does mean, what it may or could mean, and what it does not mean. Considerable concern has been expressed in many quarters about the implications of this decision, and it does indeed raise some serious considerations for HIV-positive people. However, in addition to being paternalistic, it would also be irresponsible and do a disservice to people with HIV/AIDS to shy away from a "hard look" at the nuances and possible implications of the decision. The Paper has sought to provide this careful analysis, and educated guesses as to the possible "ripple effects" of *Cuerrier* are not to be taken as approving or encouraging such effects.

However, care must be taken not to overstate the impact of the Supreme Court's final decision in *R* v *Cuerrier*. The Paper's second function is to present a community-based perspective on how the *Cuerrier* decision should and should not be interpreted and applied. In this respect, the goal of the exercise is to prevent the further undermining of HIV prevention strategies that are more effective than criminal prosecutions and will minimize the detrimental impact on the provision of support and services to HIV-positive people. The Supreme Court's judgment in *Cuerrier* itself offers a caution against an overly broad interpretation of the decision and an overly eager resort to the criminal law in light of the complexity of the issues raised by such cases:

> The phrase "significant risk of serious harm" must be applied to the facts of each case in order to determine if the consent given in the particular circumstances was vitiated. Obviously consent can and should, in appropriate circumstances, be vitiated. Yet this should not

> be too readily undertaken. The phrase should be interpreted in light of the gravity of the consequences of a conviction for sexual assault and with the aim of avoiding the trivialization of the offence. It is difficult to draw clear bright lines in defining human relations particularly those of a consenting sexual nature. There must be some flexibility in the application of a test to determine if the consent to sexual acts should be vitiated. The proposed test may be helpful to courts in achieving a proper balance when considering whether on the facts presented, the consent given to the sexual act should be vitiated.[172]

It is difficult to draw clear bright lines in defining human relations particularly those of a consenting sexual nature. There must be some flexibility in the application of a test to determine if the consent to sexual acts should be vitiated.

As has been affirmed by the Law Reform Commission of Canada:

> [C]riminal law is not the only means of bolstering values. Nor is it necessarily always the best means. The fact is, criminal law is a blunt and costly instrument – blunt because it cannot have the human sensitivity of institutions like the family, the school, the church or the community, and costly since it imposes suffering, loss of liberty and great expense....
>
> So criminal law must be an instrument of last resort. It must be used as little as possible. The message must not be diluted by overkill.… Society's ultimate weapon must stay sheathed as long as possible. The watchword is restraint – restraint applying to the scope of the criminal law, to the meaning of criminal guilt, to the use of the criminal trial and to the criminal sentence.[173]

[172] *Cuerrier*, supra, note 1 at 53-54

[173] Law Reform Commission of Canada. *Our Criminal Law*. Ottawa, 1976, at 27-28.

Summary of Recommendations

Recommendation 1

Courts should only consider "high risk" activities, as defined in current risk-assessment guidelines, as posing a legally "significant" risk of HIV transmission for the purposes of the criminal law. Those activities that carry only a "low" or "negligible" risk should not be considered "significantly" risky in a legal sense and should therefore not sustain a criminal prosecution for non-disclosure of HIV-positive status. This should be clarified by the courts in their interpretation of *Cuerrier*.

Recommendation 2

In interpreting *Cuerrier* as applying only to non-disclosure before engaging in "high risk" activity, courts should expressly recognize a "safer sex" defence, meaning that HIV-positive people who use condoms for penetrative sex or who otherwise modify their conduct so as to avoid "high risk" activities are not criminally liable if they do not disclose their serostatus.

Recommendation 3

Police and prosecutors should refrain from criminal prosecutions in the absence of evidence of "high risk" conduct without disclosure by an HIV-positive person. Attorneys General should direct Crown attorneys accordingly.

Recommendation 4

Educational materials and information for people with HIV/AIDS needs to be clear that engaging in "high risk" activity (eg, unprotected vaginal or anal intercourse) without disclosing serostatus could result in criminal liability. Such education must also convey that presently the criminal law is not clear as to whether it requires disclosure of HIV-positive status before engaging in "low risk" activities (such as unprotected oral sex, or vaginal or anal intercourse with the use of a condom). In all likelihood, disclosure is not required before engaging in "negligible risk" activities. "No risk" activities do not require disclosure.

Recommendation 5

Courts should adopt a contextual approach in interpreting and applying *Cuerrier*. Such an approach should include a recognition that, even if an activity poses a "significant risk" of transmitting HIV, an objective assessment of whether not disclosing is "dishonest" should be made only in light of all the circumstances of the case. Where an HIV-positive person honestly believes there is a risk of physical violence to them if they disclose their status to a sexual partner, then it should not be considered "dishonesty" sustaining criminal liability if they do not disclose their status. A contextual analysis should not necessarily be limited to the risk of physical violence; all the circumstances of the case should be assessed in determining whether not disclosing was "objectively dishonest," and other adverse consequences of disclosure may suffice to relieve against a duty to disclose.

Recommendation 6

Education about the *Cuerrier* decision for people with HIV/AIDS should not advise people that the risk of physical violence or other adverse consequences relieves them of any duty to disclose their status if an activity poses a significant risk of transmission, but rather should indicate that the law is unclear in this area. Public health workers and counselors at other organizations need to assist people with HIV/AIDS to reduce the risk of violence or other adverse consequences in these circumstances so as to facilitate disclosure, which may be required by law.

Recommendation 7

Courts, prosecutors, and police should consider *Cuerrier* as requiring disclosure of HIV-positive status before engaging in activity posing a "significant" risk of transmission, if that status is known to the accused as a result of scientifically accepted confirmatory testing procedures. The decision should not be taken as extending a duty of disclosure beyond disclosure of a known HIV-positive status.

Recommendation 8

Education for people living with HIV/AIDS should include the following:

- *Assault* charges could be upheld where an HIV-positive person directly injects another person with used injection equipment, and probably do not apply where the HIV-positive person's injecting partner injects themselves. However, other criminal charges might be laid in circumstances where an

HIV-positive person does not directly inject another, but provides contaminated injection equipment without disclosing their serostatus.

- Because of doubts about its efficacy as a precaution, cleaning injection equipment before another person uses it to inject *may* not be sufficient on its own to avoid criminal liability. If injection equipment is shared at all, even if cleaned between users, an HIV-positive person may still have a duty to disclose their serostatus to the person using their equipment.
- Disclosing HIV-positive status to a person who shares injection equipment may also not be, on its own, an adequate defence to criminal liability, because Canadian law may not recognize as valid the other person's consent to having someone else infect them with HIV.
- Both disclosure of HIV-positive status *and* cleaning injection equipment *may* be sufficient to avoid criminal liability, but this has not yet been decided by the courts.
- Eliminating the risk of HIV transmission entirely by not sharing injection equipment is the only sure way for an HIV-positive person to avoid criminal liability.

Recommendation 9

Courts and prosecutors should accept, at least, that there is no criminal liability attaching to the person who both discloses their HIV-positive status *and* cleans injection equipment before its use to inject another. This recognizes the prerogative of their equipment-sharing partner to choose to run the known, low risk that they may be infected through the use of that equipment. Imposing criminal liability where the HIV-positive person both discloses and cleans the equipment would overextend the criminal law and undermine sound public health policy.

Recommendation 10

Consistent with current guidelines, HIV-positive mothers should be counseled to refrain from breast-feeding their infants, and should also be aware that breast-feeding could carry the risk of criminal prosecution for assault (or other offences).

Recommendation 11

Governments, health and social services officials, health-care workers, and organizations working with HIV-positive women should ensure that information and necessary supports are available to enable HIV-positive mothers to refrain from breast-feeding, including financial assistance where necessary to ensure access to substitutes for breast milk.

Recommendation 12

The *Cuerrier* decision should not be interpreted as imposing criminal liability on an HIV-positive health-care worker for not disclosing their HIV-positive status, if they have followed established professional guidelines regarding universal precautions and expert advice regarding "exposure-prone procedures."

Recommendation 13

Physicians or public health workers conducting partner notification must still ensure that all a person's circumstances (including concern about safety) are taken in account in determining when and how to notify partners of their possible exposure to HIV infection. The decision in *Cuerrier* imposing a duty to

disclose on an HIV-positive person before engaging in activities posing a "significant risk" of transmission should not mean that public health workers derogate from this guideline and practice.

Recommendation 14

Public health officials and front-line workers, and health-care workers responsible for providing pre- and post-test counseling and who engage in partner notification, must incorporate into their counseling practice the provision of accurate information about when the criminal law may impose a duty to disclose HIV-positive status, such that not disclosing in those circumstances may give rise to criminal liability.

Recommendation 15

Access to anonymous (or at least flexible non-nominal) testing needs to be improved, in order to counteract any detrimental effect on testing that may flow from the knowledge that not disclosing HIV-positive status may result in criminal prosecution.

Recommendation 16

Research is required into the effects of coercive public health approaches and the use of criminal sanctions for non-disclosure on people's willingness to get tested for HIV infection and to access care and support services, particularly among those at higher risk of infection.

Recommendation 17

Public health departments and officials should ensure their policy and practice with respect to interventions vis-à-vis individuals who place others at significant risk of infection provides for a graduated response, guided by the principle of "least intrusive, most effective" practice. Experiences and best practice models regarding such interventions should be shared among health units within and between provinces.

Recommendation 18

Prosecutors should consult with public health authorities before laying or pursuing criminal charges, to determine whether measures under public health legislation offer an alternative to prosecution.

Recommendation 19

If necessary, legislation, regulation, and policies should be amended to ensure adequate procedural safeguards (eg, automatic review of orders, rights to appeal and to representation by counsel) against the misuse of coercive public health powers.

Recommendation 20

AIDS service organizations and other community-based organizations should consider developing policies or protocols for the guidance of staff (and possibly volunteers) who may or do come into possession of information about conduct by an HIV-positive person who risks transmitting the virus. Such policies should address the development and parameters of a counseling relationship, possible professional and legal obligations on counselors to breach confidentiality in some circumstances, and how to respond to requests by police or prosecution for disclosure of confidential counseling records.

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Appendix

Workshop Participants and People Consulted

Jo-Ann Ackery	City of Toronto Health Department
Alix Adrien	Unité des maladies infectueuses, Hôpital général de Montréal
Joan Anderson	AIDS Committee of Toronto
Ronda Besner	Legal and policy consultant
Louise Binder	Voices of Positive Women and Canadian Treatment Advocates Council
Ruth Carey	HIV/AIDS Legal Clinic Ontario
John Carlisle	Deputy Registrar, College of Physicians & Surgeons of Ontario
David Corbett	Eberts, Symes, Street & Corbett, Barristers & Solicitors
Marlys Edwardh	Ruby and Edwardh, Barristers & Solicitors
Angela Favretto	Health Canada (HIV/AIDS Prevention & Community Action Program)
John Gaylord	AIDS Committee of Toronto
Ralf Jürgens	Canadian HIV/AIDS Legal Network
Marie Klaassen	City of Toronto Health Department
Sara MacMartin	Kingston, Frontenac, Lennox & Addington Health Unit
Diana McVeen	City of Toronto Health Department
Matthew Perry	HIV/AIDS Legal Clinic Ontario
Greg Robinson	AIDS Action Now!

Michael Sobota	AIDS Committee of Thunder Bay
Lori Stoltz	Goodman and Carr, Barristers & Solicitors
Darien Taylor	Health Canada
David Thompson	AIDS Community Care Montreal
Robert Trow	Hassle-Free Clinic (Toronto)
Micheal Vonn	AIDS Vancouver
Tasha Yovetich	Canadian AIDS Society