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

417, rue Saint-Pierre, suite 408
Montréal (Québec) H2Y 2M4

Tél: (514) 397-6828
Fax: (514) 397-8570

info@aidslaw.ca
www.aidslaw.ca

Canadian HIV/AIDS Legal Network

Brief to the House of Commons Standing Committee on Justice and Human Rights

Bill C-217
("Blood Samples Act")

19 February 2002

Introduction

The Canadian HIV/AIDS Legal Network welcomes the opportunity to provide input on Bill C-217, the proposed *Blood Samples Act*. The Legal Network supports measures to prevent the spread of HIV, including for workers such as police officers, firefighters, and health care workers and good Samaritans. The Legal Network also supports access to quality HIV testing and counselling, and access to care, treatment and support, for those who may be exposed to the risk of HIV infection, whether occupationally or otherwise. Finally, we support measures that respect and protect the rights of people living with HIV/AIDS and those vulnerable to infection.

However, in our view, Bill C-217 does not represent an appropriately balanced policy response to the issue of occupational and non-occupational exposures to HIV. Sometimes a legal "quick fix" is not the solution to a difficult problem, and in any event, workers who have been exposed to the risk of blood-borne infection deserve a better response from legislators, a response that would do more to protect them. This brief explains why Bill C-217 is of concern and represents an inappropriate response.

About the Canadian HIV/AIDS Legal Network

The Canadian HIV/AIDS Legal Network is a national charitable organization engaged in education, legal and ethical analysis, and policy development. We have 250 members across Canada, about half of whom are community-based organizations with an interest in HIV/AIDS issues.

We promote responses to HIV/AIDS that:

- implement the International Guidelines on HIV/AIDS and Human Rights;
- respect the rights of people with HIV/AIDS and of those affected by the disease;
- facilitate HIV prevention efforts;
- facilitate care, treatment, and support of people with HIV/AIDS;
- minimize the adverse impact of HIV/AIDS on individuals and communities;
- address the social and economic factors that increase vulnerability to HIV/AIDS and to human rights abuses

We produce, and facilitate access to, accurate and up-to-date information and analysis on legal, ethical, and policy issues related to HIV/AIDS in Canada and internationally.

The Network has been involved in extensive government, community, and international consultations regarding all issues related to HIV/AIDS. Issues relating to HIV testing and disclosure have been a key part of the Network's information-providing activities. In 1998, we produced *HIV Testing and Confidentiality: Final Report*, containing an extensive analysis of

various aspects of Canadian law and policy in these areas. In 2000, we produced *Rapid HIV Screening at the Point of Care: Legal and Ethical Questions* that addressed numerous questions related to the introduction of rapid HIV test kits in Canada. In 2001 we produced *Testing of Persons Believed to Be the Source of an Occupational Exposure to HBV, HCV, or HIV: A Backgrounder*.[1]

1. Risks and management of occupational exposures

1.1 HIV

Risk of transmission

Almost all available data on the risks of occupational transmission of HIV comes from exposures in health-care settings. The US Centers for Disease Control and Prevention and the BC Centre for Excellence in HIV/AIDS have estimated that the risk of infection from a single *percutaneous* exposure (i.e., under the skin through a needle stick or cut) to HIV-infected blood is 0.3% (1 in 300). In other words, **99.7% of such exposures do not lead to infection**. This kind of direct, under-the-skin exposure to contaminated blood is the most significant.

The risk of infection is lower for *mucotaneous* exposures (i.e, to mucous membranes through a splash to eyes, nose or mouth), at about 0.1% (1 in 1000). If the HIV-positive source person is taking antiretroviral drugs, the chance of infection is lowered further, because the drugs reduce the amount of virus in their blood (even to the point of undetectability). If the HIV status of the source person is unknown, statistically the chance of infection is lower still.

These very low risks are reflected in the fact that there have been only two probable cases of occupational transmission of HIV in Canada, and only one definite case. The two probable cases involved laboratory workers working with contaminated blood, one in the early 1980s (before HIV was identified) and one working with cultured virus during research activities. The one definite case was that of a health-care worker not wearing gloves who sustained a puncture wound from a patient in the late stage of AIDS (when body fluids have elevated concentrations of HIV) and who did not seek post-exposure treatment with anti-retrovirals.

There is little data on occupational exposures among emergency responders outside health-care settings (e.g., firefighters, ambulance attendants, police and correctional staff). One study of

[1] T de Bruyn. *Testing of Persons Believed to Be the Source of an Occupational Exposure to HBV, HCV or HIV: A* Backgrounder. Montreal: Canadian HIV/AIDS Legal Network, 2001. A copy of the backgrounder has been provided to Committee members. Unless otherwise indicated, data and studies referenced in this brief are drawn from the discussion in the *Backgrounder*. Please refer to the backgrounder for citations to the original sources. The backgrounder is available in English and French on-line at: http://www.aidslaw.ca/Maincontent/issues/testing.htm.

police officers in the United States found that one-third of exposures reported by police officers were "significant." These exposures were rarely percutaneous or mucotaneous exposures to blood (most exposures were to non-intact skin), but when they were, they occurred in circumstances where precautions were not an option or would not have been effective. Of the identified source persons, 94% consented to HIV testing. None of the police officers in the study were infected.[2]

More recently, the Chief Medical Officer of Health for Ontario told a committee of that province's legislature that there have been no documented cases of "emergency services workers" (meaning police officers, firefighters and ambulance attendants) acquiring blood-borne pathogens occupationally in Ontario or in Canada.[3]

Post-exposure prophylaxis

Following an occupational exposure to HIV, if *post-exposure prophylaxis* (PEP) is indicated, it will consist of treatment with two or three anti-retroviral drugs for a recommended period of 4 weeks. The decision whether to recommend or offer PEP depends on assessing the degree of risk incurred in the exposure. Ideally, PEP should be started within a few hours of exposure.

There are side effects for roughly three-quarters of those taking PEP. The most common are nausea, malaise or fatigue, headache, vomiting and diarrhea. According to the US Centers for Disease Control and Prevention, these symptoms can often be managed with anti-nausea or anti-diarrhea medications that target these symptoms without changing the regimen, and in other cases modifying the dose interval (i.e., administer a lower dose more frequently) may help with adherence to the regimen.[4] However, not all side effects can be adequately mitigated. Side effects due to PEP result in significant time off work. They are also a main reason for not completing the full course of PEP. Adverse side effects usually cease when treatment is stopped.

[2] RE Hoffman et al. Occupational exposure to human immunodeficiency virus (HIV)-infected blood in Denver, Colorado police officers. *American Journal of Epidemiology* 1994; 139(9): 910-917.
[3] Dr Colin D'Cunha, Chief Medical Officer of Health for Ontario. Submission to the Standing Committee on Justice and Social Policy, Legislature of Ontario, 4 December 2001.
[4] US Public Health Service (Centers for Disease Control and Prevention). Updated US Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV and HIV and Recommendations for Postexposure Prophylaxis. *MMWR* 2001; 50 (No. RR-11) (29 June 2001) (www.cdc.gov/mmwr/PDF/RR/RR5011.pdf) [hereinafter "CDC Guidelines"].

1.2 Hepatitis B

Risks of transmission

A preventive vaccine for HBV is available, and those vaccinated are at virtually no risk of infection. All emergency responders and health care workers should, as a matter of occupational safety, be offered this vaccine as a truly protective measure against an occupational hazard. Many members of the general public have also received this vaccine or have developed a natural immunity as result of exposure.

Post-exposure treatment

If the exposed person has not been vaccinated before the exposure, the post-exposure prophylaxis will consist of hepatitis B vaccine and possibly hepatitis B immune globulin (HBIG). HBV vaccination is safe, and reports of any serious adverse effects receiving HBIG have been rare.[5] In addition to helping prevent HBV infection if the person has been exposed, being vaccinated is also obviously to the benefit of the exposed person in the event of future exposures.

1.3 Hepatitis C

Risk of transmission

There is no preventive vaccine for HCV. However, according to the US Centers for Disease Control and Prevention's most recent guidelines on managing occupational exposures, HCV "is not transmitted efficiently through occupational exposures to blood."[6] The risk of infection from a single percutaneous exposure to HCV-infected blood – the highest degree of exposure – is estimated to be 1.8%. The risk of infection following mucotaneous exposure is not known exactly but is believed to be very small. Saliva and urine cannot transmit HCV (or HBV or HIV) unless visibly contaminated by blood.

Post-exposure treatment

Unfortunately, there is no post-exposure prophylaxis for exposure to HCV.

[5] Ibid, at 5.
[6] CDC Guidelines, *supra* note 4.

2. What benefits might Bill C-217 offer to exposed persons?

There are three benefits for people exposed to HIV, HCV or HBV that are said to flow from legislation such as Bill C-217. Information about the source person's serostatus is said to benefit the exposed person because it can be used:

(1) to inform the exposed person's decisions about post-exposure prophylaxis;
(2) to inform the exposed person's decisions about precautions to prevent secondary transmission; and
(3) to alleviate anxiety about the possibility of infection.

Each of these are important considerations, and exposed persons need accurate information and support following occupational exposures. But the purported benefits of legislation such as Bill C-217 in these three areas are subject to important qualifications that must be remembered, both in assessing the balance of benefits and harms that such legislation carries and in the interests of ensuring exposed persons are given the information they need.

2.1 Limited number of circumstances in which Bill C-217 would offer any potential benefit

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

- there has been a significant exposure to the risk of infection;[7]
- the source person is available to be tested; and
- the source person does not consent to testing.

This means that, in the vast majority of cases of occupational exposure, Bill C-217 will be unnecessary.

It should be remembered that most of those who are likely to be occupationally exposed to HBV have likely already received a very effective preventive vaccine. This means there will be few cases in which an occupational exposure to HBV will carry any significant risk of the exposed person being infected. In the case of HCV and HIV, it would only be those cases of occupational exposure to blood (and not fluids such as saliva, sputum, urine, etc) that could be considered a significant exposure. This means that it is a much smaller subset of cases of occupational exposure where there might be a great enough concern about the risk of infection to consider justifying testing the source person.

[7] Note that in the case of HBV, if the exposed person has already received the very effective preventive vaccine, there will be few significant exposures that would carry any appreciable risk of the exposed person being infected.

Furthermore, the Standing Committee has heard previously (including from the Honourable Member who introduced Bill C-217[8]) that in the overwhelming majority of cases of occupational exposure, the source person consents to testing. Certainly the available evidence confirms this. For example, the study previously mentioned of exposures among US police officers reported that 94% of source persons consented to testing. And the Committee has heard previous testimony from an Alberta physician specializing in infectious diseases that in the case of exposures to health care workers in hospitals, roughly 99% of patients consent to being tested, leading him to point out that if the only exposures were occupational in the health care setting, he would not be in favour of this type of legislation.[9] In the first six months of study by the Canadian Needle Stick Surveillance Network, 83% of known source persons agreed to be tested.[10]

We have not seen the evidence that source persons are frequently unwilling to provide a blood sample for testing, and the available evidence is to the contrary. It may well be that in some cases the person refuses, but we submit that stronger evidence of a significant problem should be required before we step onto the slippery slop of passing legislation that authorizes testing people for HIV without their consent, particularly when there are limited benefits to the exposed person (as is discussed more fully in the following sections).

2.2 Making decisions about post-exposure prophylaxis

HIV

The person occupationally exposed to HIV must make a decision as to whether to initiate PEP. While the effectiveness of PEP for HIV has yet to be fully proven, there is good indirect evidence and theoretical support for its use in appropriate circumstances. Current medical advice is that it must be initiated within a matter of hours after the exposure if it is to have any likely effect.

But it is highly unlikely that in such a short period of time it will be possible to arrange a judicial hearing to obtain a warrant (which procedural safeguard in the face of infringing constitutionally-protected rights is required),[11] draw a blood sample from the source person if the

[8] Hon. Chuck Strahl, Member of Parliament. Evidence to the House of Commons Standing Committee on Justice & Human Rights, 12 December 2001.
[9] Dr Steven Shafran, Professor of Medicine, Director of Infectious Diseases Division, University of Alberta Hospital. Evidence to the House of Commons Standing Committee on Justice & Human Rights, 14 June 2000.
[10] S Onno. Oral presentation at the 9th Annual Conference of the Canadian Association of Nurses in AIDS Care, 2001. For discussion, see Backgrounder, *supra* note 1 at 7.
[11] E.g., see: *R* v *Dyment*, [1988] 2 SCR 417 at 438.

warrant is obtained, and then receive test results. In any event, even if these test results were to be obtained within a matter of a few hours – either through some startlingly expedited process or the use of "rapid tests" on-site – we must remember that testing the source person provides only some of the information needed to answer the exposed person's question about whether or not they are at risk and should initiate PEP.

With respect to rapid tests, it should also be noted that these are *screening* tests which do not provide the confirmed test results currently available through careful laboratory procedures that consist of repeated testing using different kinds of tests. In fact, they are designed to be over-sensitive so as not to miss any possible case of HIV infection. The result is that many initially positive test results using rapid tests are in fact false positives. For example, recent annual statistics for Ontario showed that two-thirds of all initially positive results turned out to be false positives upon further confirmatory testing.[12] A similar ratio has been reported for tests conducted at various sites in Alberta.[13]

So what is being proposed then is to authorize compulsory HIV testing when in the short period of time during which it might be of any possible benefit all that would be available is an unreliable test result. The person is still confronted with decisions about post-exposure prophylaxis. If the source person were to test HIV-positive on one of these rapid tests, obviously this might encourage the person to decide they definitely need to take the PEP regimen. Who, upon receiving that initial positive result, which could very well be an inaccurate or false positive result, would want to take the risk of forgoing the drug regimen if there has been what they consider a significant exposure?

As has been noted, some people choose to discontinue PEP if the source person tests HIV-negative. Even if the source person tests HIV-negative, while this provides some reassurance, it does not fully rule out the possibility that the exposed person might still be infected. The source person might still be within the "window period", having been infected but not yet registering as such on the test.[14] The window period is indeed a moving target, and advances in testing technology have reduced it significantly, but it remains a concern which the exposed person needs to understand.[15]

It would be particularly of concern if the source person had recently engaged in high-risk activities, such as sharing injection equipment or having unprotected sex. If this fact were known

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[12] See: R Elliott, R Jurgens. *Rapid HIV Screening at the Point of Care: Legal and Ethical Questions*. Montreal: Canadian HIV/AIDS Legal Network, 2000. Available on-line in English and French via www.aidslaw.ca.
[13] Communication with Dr. Bryce Larke, Chair of the Federal/Provincial/Territorial Committee on AIDS, 2000.
[14] Please refer the Backgrounder (at pp. 15-18) for a description of different testing technologies available for HIV, HCV and HBV.
[15] Obviously, reducing the window period between infection and detection also means that the time the exposed person must wait before being "in the clear" is also shortened.

to the exposed peace officer or health care worker – as it might well be in some circumstances that you can envision, such as the police officer stuck with a needle in the course of searching someone incident to their arrest – then no doubt it would be particularly such cases in which the exposed person would be concerned about possible infection. That is when their concern about the possibility of a false negative result would no doubt be greatest.

The results of testing the source person can provide useful information for making decisions about PEP, and if available should be taken into account (along with other information such as risk factors of the source person, the nature of the exposure, the source person's previous treatment history using anti-retroviral drugs, etc) in making a decision about PEP. But often that additional information is not available, and the limits of the test results need to be fully understood.

The question is: does it offer such a benefit to the exposed person, in that handful of cases where there has been a significant exposure and the source person does not consent to testing, that it justifies overriding other important rights of the source person, with the attendant harms, in all of the circumstances currently covered by the broad language of Bill C-217?

HBV

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

HCV

Unfortunately, there is no preventive vaccine against HCV, nor is there a known effective post-exposure prophylaxis. In the absence of such medical options, testing the source person cannot assist with decisions about stopping or starting post-exposure prophylaxis, meaning this is not a compelling rationale for compulsory testing of the source person for HCV.

2.3 Preventing secondary transmission

HCV & HBV

The person exposed to blood infected with HCV or HBV need not take any special precautions to prevent secondary transmission during the follow-up period (such as modifying sexual practices, or refraining from becoming pregnant or breastfeeding). All they should do is refrain from donating blood, plasma, organs, tissue or semen.[16] Knowing the source person's HCV or HBV status is not necessary for this. Preventing secondary transmission is, therefore, not a compelling rationale for compulsory testing the source person for HCV or HBV.

HIV

Persons exposed to HIV should be counseled about safer sex practices and about advising their sexual partners of the potential risk of transmission, as well as counseled about avoiding other activities (e.g., sharing needles) that pose a risk of transmission. Women should avoid becoming pregnant until reasonably sure they are not infected (3 to 6 months), and if already pregnant, should be advised of the potential for anti-retroviral therapy and other interventions to considerably reduce the chance of transmitting the virus to their child during gestation or labour/delivery. Women should be counseled about the risks of breast-feeding and advised about alternatives. All of these represent temporary modifications to behaviour and can be undertaken whether or not the source person's HIV status is known.

2.4 Alleviating anxiety of the exposed person

There is no question that receiving a source person's negative test results for any of HCV, HBV or HIV can relieve some of the anxiety of the exposed person (and their loved ones) about possible infection, as it means it is statistically that much less likely that they have been infected as a result of the exposure.[17]

But equally important in achieving this goal is ensuring appropriate counseling and information is provided to the exposed person, which can and should be done without resort to compulsory testing. There have been too many reports of exposed police officers, fire fighters, health care workers or good Samaritans believing that they are at much higher risk of infection than the circumstances of their exposure indicate, or not fully understanding the extent of time required

[16] CDC Guidelines, supra note 4 (at 23).

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

for follow-up testing during which they may still test positive. This is a tremendous source of anxiety that is fully avoidable, and must be addressed through ensuring access to accurate, quality information.

Anxiety is experienced until the exposed person can be confident that they have not been infected. As the accompanying backgrounder indicates, there are various kinds of tests available for these three viruses:[18]

- Nucleic acid tests can detect HBV in the exposed person as early as 33 days following infection, HCV as early as 12 days after infection, and HIV as early as 11 days after infection.

- Antibody tests can detect HBV infection 60 days after infection, HCV as early at 70 days after infection, and HIV as early as 22 days after infection.

- The majority of people who are infected with HIV seroconvert within the first few weeks or first 3 months following exposure, and 95% will have seroconverted within 6 months following exposure. Given the very small risks of occupational infection even with percutaneous exposures to blood known to be contaminated with HIV (i.e, estimated at 0.3% likelihood), if the exposed person has not seroconverted by 3 or certainly by 6 months following the exposure, the chances of them seroconverting beyond that point are evidently exceedingly small indeed.

With respect to HIV, awareness of the truly small nature of the risks – and in industrialized countries, the very small number of emergency responders (zero in Canada) or health care workers (1 definite, 2 probable in Canada) who have been infected through occupational exposure – is critical for relieving the anxiety of exposed persons.

Knowledge of the source person's HIV test result, while having some value for decisions about PEP, may be a double-edged sword with respect to the anxiety felt by the exposed person. In cases where the source person tests HIV-positive, this information cannot but increase the exposed person's anxiety during the waiting period. The point is simply that the claimed benefit of anxiety alleviation is, as with the other benefits of knowing the source person's status, a qualified one.

[18] Backgrounder, at 16.

3. Concerns about legislation authorizing compulsory testing

The Legal Network wishes to raise concerns in four areas regarding Bill C-217:

- disregard for the ethical and legal principle of informed consent;
- various infringements of *Charter* rights without adequate justification;
- the issue of imposing compulsory testing only in some cases of exposure;
- the question of the federal government's jurisdiction to enact such a bill.

3.1 Ethical and legal doctrine of informed consent

The qualified benefits offered by compulsory testing must also be weighed against other ethical concerns, other values we consider important. The Supreme Court of Canada has repeatedly recognized that a person cannot be subjected to medical procedures without his or her informed consent.[19] This requirement has also been codified into statute in many provinces, and forms a part of the codes of ethical conduct for all health care professionals.

This legal doctrine reflects the fundamental ethical principle of respect for persons and their autonomy. This includes their bodily and psychological integrity, and it includes their right to privacy with respect to their own medical information. Respect for persons – the ethical imperative – requires that people be treated as ends in themselves, not merely as means to the ends of other people. In our view, forced testing would be unethical, in that it violates this fundamental principle. The qualified benefits noted above are not insufficient to justify this ethical violation.

In 1995, Health Canada convened a national conference that established a consensus on guidelines for a protocol to notify emergency responders when they may have been exposed to an infectious disease.[20] In 1996, Health Canada convened a meeting establishing a protocol for managing exposure to HBV, HCV and HIV among health-care workers.[21] Both reiterated that informed consent must be obtained for testing the source person.

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

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

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

3.2 Charter issues

Bill C-217 raises numerous *Charter* concerns. In our submission, the state violates the *Charter of Rights and Freedoms* if it authorizes HIV testing without consent. In particular, it infringes the rights to liberty and security of the person (section 7) and the right to be free from unreasonable seizure (section 8).

Liberty and security of the person

First and foremost, the person who refuses to comply with a court order to provide a blood sample for testing can be imprisoned for up to 6 months. What is to prevent a court from ordering the use of state force to physically compel testing in the face of a refusal to comply with the court's order? Peace officers are entitled to use reasonably necessary force to enforce the law. The infringement of both liberty and security of the person are evident.

Privacy: physical

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

> the use of a person's body without his consent to obtain information about him invades an area of personal privacy essential to the maintenance of human dignity... [T]he protection of the *Charter* extends to prevent a police officers, an agent of the state, from taking a substance as intimately personal as a person's blood from a person who holds it subject to a duty to respect the dignity and privacy of that person."[22]

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

The Court had said previously in one of the leading cases on section 8 of the *Charter*,[23] and reiterated in *Dyment*, that the function of the *Charter* "is to provide…for the unremitting protection of individual rights and liberties." and that a major purpose of the constitutional protection against unreasonable search and seizure is the protection of the privacy of the individual. Furthermore, that right "must be interpreted in a broad and liberal manner so as to

[22] *R* v *Dyment*, [1988] 2 SCR 417.
[23] *Hunter* v *Southam*, [1984] 2 SCR 145 (at 155).

secure the citizen's right to a reasonable expectation of privacy against governmental encroachments."[24]

There has been only one reported case in Canada directly considering the question of whether a court may order HIV testing of a person against their will, with that information provided to a person claiming to have been exposed to a risk of infection. In the *Beaulieu* case, a man accused of sexual assault was brought before the court and the woman whom he had allegedly assaulted sought an order that he provide a blood sample for HIV testing. The court in that case, a Quebec trial court, expressly referred to the Supreme Court's decision in *Dyment* and said that this raises serious *Charter* concerns. The court refused the order.

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

Bill C-217 would authorize performing medical tests on people without their consent, without any requirement that there be at least a *prima facie* case of wrongdoing. Compulsory testing could be ordered for a person who has not been even charged with any criminal or quasi-criminal offence. Under Bill C-217, the accident victim unconscious by the roadside could find themselves ordered to be tested for HIV, HCV or HBV. Someone injured by a domestic assault could be compelled to be tested for these viruses. Any patient receiving health care services could be the subject of an order for compulsory testing. Failing to comply carries a penalty of up to 6 months in prison.

Privacy: psychological

The violation of bodily integrity is also compounded by a violation of psychological integrity. Bill C-217 states that the source person must be informed of their test results. It thus removes from them the option to decide whether and when to get tested, solely because they may have been in an accident and bleeding when paramedics or firefighters arrived. People should not hesitate to call for an ambulance out of fear they could end up getting tested for HIV without their consent.

[24] *Dyment*, *supra* note 22 at 426. In the earlier case of *R* v *Pohoretsky*, [1987] 1 SCR 945, the Court stressed the seriousness of a violation of the sanctity of a person's body as an affront to dignity.

Privacy: informational

Two years after the *Dyment* decision, the Supreme Court ruled in the *Duarte* case[25] that the *Charter* protects the right of the individual to determine for himself or herself when, how, and to what extent they will release personal information about themselves.

Because most people (as the evidence shows) would consent to being tested in the event of posing such exposure to an emergency responder or health care worker, it may be hard for many to imagine why someone might refuse testing. But there are indeed good reasons why people do not with to be tested. The loss of confidentiality about something such as HIV status can produce a whole range of negative consequences.

Stigma and discrimination related to a disease like HIV/AIDS are a reality in Canada.[26] People who admit simply to being tested for HIV (even where negative) have been denied insurance; certainly the person who tests positive will likely be unable to obtain health insurance in the future. The victim of domestic assault who tests, for example, HIV-positive faces the prospect that public health authorities in most provinces would be required to notify his or her partner, who may also be their abuser, of the partner's possible past exposure. The person who tests positive may be denied permission to become a permanent resident of Canada. Discrimination in employment, services, accommodation, membership is social or professional associations persist for people known or perceived to be HIV-positive or to have hepatitis.

Bill C-217 does not contain adequate provisions for protecting of confidentiality of the source person's test results. Indeed, it is questionable whether it could provide anything other than illusory protection. It is positive that it prohibits the use of the test results certificate as evidence in a civil or criminal proceeding. But this is of limited practical benefit. Once the source person knows their status, that information is compellable from them under oath in another proceeding. So the fact that the certificate itself is not admissible may be irrelevant. Furthermore, there are no provisions in Bill C-217 requiring that the certificate with the source person's test results be destroyed. And there is no reason for the test results to be given to the peace officer responsible for executing the warrant; all that officer needs to know is that testing has been completed.

In addition, Bill C-217 provides no protections for keeping the source person's test results confidential. It prescribes no criminal penalty, nor does it create any civil cause of action, for breaching confidentiality. Even if it did, such provisions would likely be of little practical value. Two decades of experience show that breaches of confidentiality are commonly experienced by

[25] [1990] 1 SCR 30 at 46.

[26] A series of info sheets on HIV/AIDS and discrimination have been provided to Standing Committee members. See also: T de Bruyn. *HIV/AIDS and Discrimination: Final Report*. Montreal: Canadian HIV/AIDS Legal Network, 1998. All documents are available on-line (in English & French) via www.aidslaw.ca.

people living with HIV, particularly in small or closely knit communities, and that the consequences can be devastating. In most cases, there is no effective, accessible remedy.

Prior judicial authorization dubious as safeguard against liberty, security of person and privacy

Much has been made of the fact that Bill C-217 would require prior judicial authorization for compulsory testing. Certainly it is important that there be some such scrutiny of the legitimacy of the request before people are subjected to testing without their consent. Yet this safeguard may not be as robust as some think.

With great respect, it is submitted that judges and counsel are fallible too and sometimes base their interpretation and application of the law on misinformation. This has been observed with respect to HIV, with profoundly unjust consequences.

In the 1996 case of *Thissen*, an HIV-positive person who bit a police officer for a brief moment during a scuffle upon her arrest, with no significant injury to the officer's hand, was charged with *aggravated* assault, on the theory that the bite had endangered the life of the police officer. There is no appreciable risk of HIV transmission in such circumstances. Nonetheless, after a lengthy discussion of the global scourge of HIV/AIDS (to which enormous epidemic human bites have made no apparent contribution), the court sentenced the accused to 2 years' imprisonment on a charge that should not have been laid or upheld in the first place. The accused's HIV-positive status in the case should have been irrelevant, with a minor sentence (likely not even including imprisonment) for a simple assault, as would have been the case with an HIV-negative accused.

More recently, within the past few weeks, another judge incorrectly declared that HIV could be transmitted by spitting in the course of sentencing an accused, sending out a misleading and dangerously stigmatizing message to the community about HIV and people with HIV. These examples illustrate that somehow the law must require courts to hear scientifically sound evidence regarding the modes and risks of transmission of blood-borne illnesses if they are to render legally sound and just decisions. In the absence of any such requirement, legislation such as Bill C-217 authorizing compulsory testing invites discrimination on the basis of disability (contrary to the equality guarantee in section 15 of the *Charter*) arising from inadequate understanding.

Nor does the requirement of judicial authorization necessarily address concerns about privacy at the early stage. Experience to date indicates media interest in reporting cases of occupational HIV exposure of police officers and emergency responders. It is very likely that an application for compulsory testing under legislation such as Bill C-217 would attract media attention. But

there is no requirement that media refrain from publishing the names or other identifying information about the source person in the course of reporting of the court proceeding, or any provision requiring the court hearing the application to order such a publication ban.

The "justification" analysis

In the leading case of *Oakes*,[27] the Supreme Court has set out the requirements for justifying legislation that infringes *Charter* rights under the provisions of section 1 of the *Charter*:

- the objective to be served by the measures infringing the right must relate to concerns that are "pressing and substantial" in a "free and democratic society";
- the measures must be fair and not arbitrary, carefully designed to achieve the objective in question, and rationally connected to that objective;
- the measures should impair the *Charter* right as little as possible; and
- there must be proportionality between the effects of the limiting measure and the objective – the more severe the infringement of the right, the more important must be the objective.

We agree that protecting people against occupational and non-occupational exposures to blood-borne pathogens, and helping them deal with the aftermath of such an exposure, certainly reflects pressing and substantial concerns.

We question whether, as drafted, Bill C-217 is carefully designed to achieve these objectives and is rationally connected to them. We note that various leading associations of health professionals (see below) have criticized this sort of legislation as "not warranted," "unjustified", and the Chief Medical Officer of Health for Ontario has supported the intention behind such legislation but considers that it does not realize its intention. We have noted above that the rationale for authorizing compulsory testing for HCV and HBV is quite limited.

However, accepting *arguendo* that this condition is satisfied, we submit that Bill C-217 impairs *Charter* rights in considerably more than a minimal fashion, for the reasons set out above, including:

- the potential for imprisonment and the application of physical force to conduct a medical procedure without consent;
- the invasions of physical, psychological and informational privacy represented by compulsory testing;

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

- the absence of adequate safeguards before the issuing of a warrant compelling testing;
- the absence of adequate protection for the confidentiality of the test results of the person subject to compulsory testing (which may not admit of any effective remedy once the damage of testing without consent has been done;
- the potential negative ramifications that will or will likely follow for the person who tests positive (particularly for HIV) as a result of compulsory testing;
- the viable alternatives for managing occupational (and non-occupational) exposures that seek to address many of the concerns and needs of exposed persons without infringing the rights of alleged source persons.

In light of the above, we respectfully submit that the requisite proportionality between objectives and infringement of *Charter* rights is not adequately demonstrated.

3.3 Consistency in the law: a policy consideration

Proposals such as Bill C-217 also raise the question of whether there is consistency in the law, which is desirable as a matter of policy. Bill C-217 would authorize the compulsory testing of a source person in the event that an emergency responder or health care worker were exposed in the course of their duties, or if a good Samaritan were exposed in the course of assisting another.

But what if the emergency responder, health care worker, or good Samaritan exposes the other person to the risk of infection? The same rationales about obtaining information to make PEP decisions, prevent secondary transmission and alleviate anxiety would surely apply in those circumstances. We are faced, then, with the prospect of authorizing the compulsory testing of emergency responders, health care workers and good Samaritans. Or, indeed, authorizing compulsory testing following any significant exposure of one person by another. Previously before the Standing Committee (with respect to then Bill C-244), representatives of Justice Canada raised this question.[28] It remains a question with respect to Bill C-217.

3.4 Parliament lacks jurisdiction to enact Bill C-217

As has been previously pointed out to the Standing Committee by representatives of Justice Canada, it is questionable whether the federal Parliament has the constitutional jurisdiction to enact Bill C-217, as there appears to be little or no nexus to the criminal law: "it is simply saying we can get a warrant without any kind of link or hook to criminal law as we usually understand it to be."[29] The mere fact that the bill (or least one part of the bill) proposes to amend the *Criminal*

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

Code does not answer the question of whether it properly falls, in its "pith and substance" within the federal government's power to legislation in the realm of criminal law; such an argument begs the question.

Numerous previous decisions by the Supreme Court have indicated the parameters of the criminal law power. In the view of Justice Canada, those did not suggest a basis for enacting legislation such as Bill C-217.[30] It was suggested previously to the Standing Committee that the decision of the Supreme Court of Canada in the *Firearms Reference*[31] would, if it upheld the federal government's gun control legislation, provide a basis for concluding that Bill C-217 is a valid exercise of the criminal law power. That decision has now been rendered and the Court did uphold the legislation. But with respect, it does not provide any further support for this conclusion. The Court decided the "pith and substance" of the legislation was directed at enhancing public safety by controlling access to firearms, in order to deter their misuse, control those given access o them, and control specific types of weapons. Furthermore, there was a long history of various forms of gun control that had been considered valid criminal law (and was not challenged as beyond federal jurisdiction) because guns are dangerous and pose a risk to public safety.

Bill C-217 is not aimed at protecting public safety by controlling access to, and the use of, inherently dangerous items. It is not connected to gathering evidence or information about criminal activities, about enforcing the criminal law, about prohibiting a person from exposing another to a risk of harm, etc. It is about giving health information to specific people who may have been exposed to the risk of specific infectious diseases – a matter traditionally dealt with under provincial/territorial public health or legislation regulating the workplace. Insofar as it applies to occupational exposures for certain designated classes of workers, it is fundamentally legislation relating to occupational health and safety. Insofar as it deals with good Samaritans, the connection to criminal law is equally tenuous.

[30] Ibid.
[31] [2000] 1 SCR 783.

4. Positions of other stakeholders

Health care workers are those at greatest risk of occupational exposure to blood-borne illnesses, and have by far the highest rate of incidents. But leading national associations of health care professionals do not support legislation such as Bill C-217.

- In November 2000, the Canadian Nurses Association (CNA) adopted a position statement expressing its view that compulsory testing either before or after significant exposure is "not warranted."

- The Canadian Association of Nurses in AIDS Care (CANAC) published a position statement in April 2000 on the prevention and management of occupational exposures in which it states that testing a patient without informed consent is unethical.

- The Canadian Medical Association (CMA) does not support compulsory testing. In introducing Bill C-217 to the Standing Committee, the Hon. Chuck Strahl cited a 1998 resolution of the CMA in favour of requiring patients to sign a waiver authorizing testing for HIV and hepatitis in the event of occupational exposure to the health care worker. However, the CMA subsequently examined this question further, and commissioned an epidemiological review and two legal opinions. At its 2000 General Council, the CMA rescinded its previous motion recommending compulsory testing. To this day, the CMA takes the position that "compulsory testing is unjustified." With respect to compulsory testing legislation recently enacted in Ontario, a CMA spokesperson has indicated that "there does not seem to be a need for this drastic type of law."[32]

- The Canadian Union of Public Employees (CUPE) represents members in health-care or health-related occupations at risk of occupational exposure to bloodborne pathogens, such as ambulance attendants, housekeeping staff, laundry workers, nurses aides, and laboratory technicians and technologists. CUPE does not support compulsory testing of source persons in the event of occupational exposures.

- The Ontario Public Services Employees Union (OPSEU) represents various human services workers who are occupationally exposed to infectious diseases, including many correctional staff. OPSEU does not support the proposed mandatory testing of source persons.[33]

[32] Dr John Williams, CMA Director of Ethics, quoted in: B Mackay. New Ontario law could allow force blood sample collection, *e-CMAJ*, 16 January 2002.
[33] Letter from Ms. Leah Casselman, OPSEU President to Canadian HIV/AIDS Legal Network, 20 December 2001.

Numerous other organizations have also indicated they do not support legislation such as Bill C-217.

- The Canadian AIDS Society, which represents over 100 community-based AIDS organizations in Canada, has previously informed the Standing Committee of its opposition to this bill (then Bill C-244 in the previous session of Parliament), and has more recently addressed its concerns regarding Bill C-217 to the Minister of Justice.[34]

- The Canadian Public Health Association has a long-standing opposition to compulsory HIV testing.[35]

- The Ministerial Council on HIV/AIDS, an expert committee which provides advice to the federal Minister of Health on the Canadian Strategy on HIV/AIDS, has advised the Minister that this bill, while well-intentioned, raises serious ethical and legal concerns.[36]

- Health Canada representatives have previously stated to the Standing Committee that "mandatory testing neither achieves public health goals not establishes a national environment of safety and reassurance for people considering testing."[37]

- Justice Canada representatives have also raised jurisdictional, *Charter* and policy concerns about this legislation with the Standing Committee. The Honourable Anne McLellan, then Minister of Justice and now Minister of Health, has recently stated that the government appreciates the difficulties that people exposed to the risk of infection in the performance of their duties helping other people may experience, but that "the solution to this serious problem may not be in Bill C-217," which "raises significant constitutional issues."[38]

- The Chief Medical Officer of Health has advised against Ontario adopting legislation similar to Bill C-217, describing it as “not an appropriate or effective first response from a public health perspective.” In his view, there are more effective, timely and less intrusive means “to the end of protecting or enhancing the health of emergency services workers and others.” He recognized that “there is no simple solution in these difficult cases,” but points to existing protocols for reducing and managing occupational (and other) exposures as viable and preferable alternatives.[39]

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[34] Letter from Canadian AIDS Society to Hon. Martin Cauchon, Minister of Justice and Attorney General of Canada, 25 January 2002.
[35] CPHA, 1998 Resolution (available via www.clearinghouse.cpha.ca).
[36] Letter from Co-Chairs of Ministerial Council on HIV/AIDS to Hon. Allan Rock, Minister of Health, 2001.
[37] Mr David Hoe, Policy Advisor, HIV/AIDS Policy Coordination and Programs Division, Health Canada. Evidence before House of Commons Standing Committee on Justice and Human Rights, 13 June 2000.
[38] Letter from the Hon. Anne McLellan, Minister of Justice and Attorney General of Canada to Co-Chairs of the Ministerial Council on HIV/AIDS, 4 January 2002.
[39] D’Cunha, *supra* note 4.

5. Conclusion

Compulsory testing *after the fact* is a poor compulsory testing after the fact of exposure is a poor way to "protect" workers facing this occupational hazard. Those whose work puts them at risk of exposure to infectious diseases deserve better. And Canadians deserve legislation that more carefully protects their basic rights.

Bill C-217 proposes to force HIV testing on a person not necessarily accused of any wrongdoing and to force them to learn the results of a medical test to which they have not consented, in the interests of providing (possibly inaccurate) information to another person who needs to (quickly) make a decision about a regimen of drugs. It infringes the ethical principle of respect for autonomy and privacy and the corresponding legal requirement for informed consent to medical procedures. Constitutional rights to liberty, security of the person, and privacy are infringed without adequate justification.

In our view, there are better alternatives. The first, of course, is to make sure that universal precautions are universal. This would, in many circumstances, significantly reduce the risk of any potential infection. There will be some circumstances in which universal precautions are not really practicable. But that unfortunate reality does not necessarily mean we should be creating legislation to impose forced testing. Sometimes the law does not provide an answer.

Second, we should legislate the use of safer needles and syringes in health care settings, as a workplace safety measure, to reduce the likelihood of needle-stick injury, the most common occupational exposure to HIV or other blood-borne pathogens in a health care setting.

Third, we need to ensure timely access to testing for HIV and hepatitis B and C for any exposed person, as well access to proper information, counselling, and support and free PEP where this exists. This will be of greater benefit to exposed persons than forcing another person to be tested.

Finally, we need to take measures to make it safer for source persons to be tested voluntarily. For example, give the source person the option to not receive the test results. Destroy test results unless the source person requests otherwise. Protect confidentiality better and strengthen protections against HIV-related discrimination. Encouraging voluntary testing will better achieve the ostensible goal of this bill without damaging the persons and privacy of Canadians living with hepatitis or HIV or AIDS.