Disclosure of HIV Status After *Cuerrier*:

Resources for Community Based AIDS Organizations

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Canadian AIDS Society
Société canadienne du sida

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

AIDS COALITION of Nova Scotia

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Disclosure of HIV Status After *Cuerrier*: Resources for Community Based AIDS Organizations

1 Disclosure of HIV Status: A Difficult Issue

This section of the Resource Guide can be used to:

- Find out what the Resource Guide is about and why it was written.
- Identify whom the Resource Guide was written for.
- Get information about how to use the Resource Guide.
- Get a brief introduction to the criminal law related to HIV disclosure.

A Resource Guide for Community

People living with HIV/AIDS (PHAs) have been convicted and sentenced to jail for putting their sexual partners at significant risk of HIV infection. In the future, courts may convict PHAs for sharing injection drug equipment that contains HIV-infected blood. This is a reality PHAs and community based AIDS organizations (CBAOs) must live with and respond to. This Resource Guide is intended to provide useful information so PHAs and CBAOs can make informed and empowered choices about how to respond to this reality.

It is up to each CBAO to choose how to respond to the legal and ethical issues related to HIV disclosure and client confidentiality. Whatever the response, **CBAOs and other community based organizations serving PHAs should consider developing policies and guidelines about HIV disclosure, counselling and client confidentiality if they have not already done so.** An organization can develop its own policies and guidelines or adapt existing ones. Either way, **policies and guidelines should be based on a sound understanding of the relevant legal and ethical issues and a realistic assessment of the practical and political situation that the organization works within.**

The Resource Guide is **for CBAOs**. The **information and tools in it can be used to address client and organizational issues related to disclosure of HIV status and to help CBAOs develop policies and guidelines.** It is also for **people who counsel PHAs**, whether they do so as a CBAO staff member or a volunteer.

The Resource Guide is for:

- CBAO staff and volunteers who counsel PHAs (whether or not they are regulated professionals)
- CBAO Boards of Directors and Executive Directors (EDs)
- Other agencies and organizations in which staff and volunteers counsel PHAs

Use the Resource Guide to **learn more about the disclosure of HIV status and …**

- criminal law, public health law and civil liability
- client confidentiality and record-keeping
- counselling standards and approaches
- how to respond to the media and the public

Use this Resource Guide to **counsel and give information to clients** about HIV disclosure and the law.

Use the Resource Guide to **develop or adapt for** your organization:

- a client confidentiality and record-keeping policy
- guidelines for counselling PHAs
- client information materials about HIV disclosure

How to Use this Resource Guide

Each chapter of the Resource Guide begins with a brief table of contents for that chapter, followed by a section called "This section of the Resource Guide can be used to". The Resource Guide was designed to be used by different CBAOs to meet their different needs.

The Resource Guide contains **information** and **tools**. The information is about law, ethics and counselling related to HIV disclosure. You can use this Resource Guide to **get and give accurate, comprehensive information about HIV disclosure, law and ethics**. Each chapter can be used to meet a specific need for information. For **example**:

- Counsellors can use **Chapter 4** (What PHAs Need to Know About the Criminal Law) as a basis **to give legally accurate information to clients about criminal law and HIV disclosure**, either through in-person counselling, by developing information sheets, or any other means of communicating information.

- CBAOs can use the information in **Chapter 7** (Client Confidentiality and Record Keeping), in tandem with the sample policies at the end of that chapter, **to develop and adopt a policy on client confidentiality**.

The Resource Guide also contains **tools** like an information sheet, checklists, decision-making trees, tables and sample guidelines and policies. For **example**:

- A counsellor can use the **table in Chapter 4** (What PHAs Need to Know About the Criminal Law) to answer client questions about whether they have a legal duty to disclose their HIV status before engaging in specific injection drug and sexual activities, and explain the legal risks involved.
- If a police officer shows up at the CBAO with a search warrant for a client's file, the CBAO can use the **step-by-step checklist in Chapter 7** (Client Confidentiality and Record Keeping) to take measures to protect the confidentiality of the client's information.
- An executive director (ED) or manager of programs can use the **Legal and Ethical Counselling Standards in Chapter 6** (Counselling and HIV Disclosure: Standards and Approaches) to develop guidelines for CBAO staff and volunteers.

Counsellors and CBAOs can use these **tools** as they are, or adapt them to their needs.

This Resource Guide is not a substitute for legal advice about a particular situation. It provides analysis and information about the legal and ethical issues related to HIV-disclosure that are commonly faced by CBAOs. It is a reference and a resource. Counsellors can use it on a day-to-day basis to find out their legal and ethical responsibilities. Counsellors can also use it to give clients information about client rights and responsibilities. Boards and EDs can use it to find out about the organizations' rights, responsibilities, and potential liabilities. A counsellor may still want to get legal advice about particular client situations. The ED of Board of Directors may want to have a lawyer review a policy before it is passed by the Board.

This Guide Is Not About Hepatitis C Disclosure

This Resource Guide is about issues related to HIV disclosure. It is not about Hepatitis C disclosure, and the legal issues related to Hepatitis C transmission. From both a medical and legal point of view, HIV infection and Hepatitis C infection are very different. Therefore, the legal and counselling issues related to Hepatitis C disclosure are different.

Medically, some of the routes of HIV transmission are the same for Hepatitis C virus transmission. Some are not. There is no cure for HIV while some people with Hepatitis C can be cured with treatment.

Legally, the Supreme Court's ***Cuerrier*** decision criminalized behaviour by PHAs that put other people at significant risk of HIV transmission. The ***Cuerrier*** case did not deal with the risk of Hepatitis C transmission. There is only one reported criminal court case about Hepatitis C transmission, from a lower court. The court decided that exposing a partner to Hepatitis C through sex was not criminal because the risk of transmission by unprotected intercourse was extremely low. Based on this one lower court case, we really don't know enough from a legal point of view to say how a court might deal with a future case about Hepatitis C transmission.

Disclosure Defined

Disclosure is the act of informing others of a person's HIV status. A PHA may disclose his or her HIV status. Or, someone else may disclose a PHA's HIV status, either with or without the PHA's consent to do so.

Disclosure can occur in many contexts: disclosure within personal relationships (to lovers, partners, spouses, children, friends and other family); disclosure in the workplace (to an employer, other employees, clients); disclosure to health and other service providers (physicians, emergency services, dentists, social workers, insurers, etc.); disclosure in an institutional setting (prisons, schools, etc.), and disclosure to the general public via the media.

The focus of this Resource Guide is disclosure by HIV-positive people to their sexual and injection drug partners. PHAs who engage in unprotected sexual

activities and share drug injecting equipment run a significant risk of transmitting HIV to their sexual and drug injecting partners. Some people say that PHAs have an ethical and legal obligation to disclose their HIV status to their partners whenever there is a significant risk of HIV transmission. Certainly, PHAs face potential criminal and civil legal liability if they do not disclose their HIV status where there is a significant risk of transmitting HIV.

PHA Perspectives on Disclosure

Disclosing one's HIV status is not easy. HIV status is intensely personal information and the act of disclosure can lead to both positive and negative results. This is why PHAs are **entitled to control over this crucial decision**. PHAs are **entitled to the information they need to decide** if, when and how they will tell other people about their HIV status — including information about their obligations under the criminal law.

The topic of disclosure of HIV status has been the subject of discussion, debate and deliberation since the beginning of the AIDS epidemic. Most of the discussion and debate has been about people who do not disclose their HIV status before they engage in behaviours with a high risk of transmitting HIV. **The focus on HIV-positive people who put others at risk of HIV transmission has distorted the discussion and made life more difficult for people living with HIV.** It has reinforced the climate of fear, stigma, discrimination that surrounds HIV infection and has even resulted in violence against some PHAs. It has made it more difficult for many PHAs to disclose their HIV status.

Canadian Criminal Law and the Duty to Disclose HIV Status

In September 1998, the Supreme Court of Canada released its judgment in ***R v Cuerrier***. This was the first time that Canada's highest court dealt with the criminal prosecution of an HIV-positive person for having sex without disclosing his or her HIV status. The Court concluded that an HIV-positive person who engages in unprotected vaginal intercourse without disclosing his HIV status could be convicted of aggravated assault under the Criminal Code.

Since the ***Cuerrier*** case, every HIV-positive person has a legal obligation to disclose his or her HIV status where he or she engages in a sexual activity that poses a **significant risk of serious bodily harm** (in other words, transmission of HIV) to another person. In September 2003, the Supreme Court released its judgment in ***R v Williams***. The Supreme Court found a person who knows that he or she is HIV-positive cannot be convicted of aggravated assault for having unprotected sexual intercourse without disclosing HIV status where there is a reasonable doubt about whether the other person was HIV-positive at the time. Instead, the person can be convicted of attempted aggravated assault. A person can be convicted of an "attempted" criminal offence where one of the necessary elements of a criminal offence is missing. While the Supreme Court's decision in ***Williams*** clarified this issue, it raised many others.

The Court's reasoning in the ***Cuerrier*** and ***Williams*** cases are complex and leave many questions unanswered. Can a PHA be charged with aggravated

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

Recommendation 20

AIDS 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 counselling relationship, possible professional and legal obligations on counsellors to breach confidentiality in some circumstances, and how to respond to requests by police or prosecution for disclosure of confidential counselling records.

assault for sharing injection drug equipment that contains HIV-infected blood? What about oral sex? If you use a condom for intercourse, do you still have to disclose? Can a PHA be held criminally liable for re-exposing another PHA to HIV?

Since the ***Cuerrier*** case, a number of PHAs have been convicted of aggravated assault for having unprotected vaginal intercourse without disclosing their HIV status. In the ***Williams*** case, Mr. Williams was convicted of attempted aggravated assault. Courts have not decided any cases about other activities that risk HIV transmission, like sharing injection drug equipment or sexual activities other than intercourse.

Leadership is Vital

HIV disclosure is also a difficult issue for people who work (or volunteer) in CBAOs that provide services to PHAs. It is a difficult issue because community based organizations are often the best or only source of information and support for PHAs. These organizations strive to provide PHAs with accurate information and ethical counselling around HIV disclosure issues.

> "In light of the *Cuerrier* decision which has highlighted the need for agencies to develop policies covering the situation where an agency is aware of a client's potentially criminal behaviour in transmitting HIV;
>
> Be it resolved that CAS explore the legal and ethical issues involved and develop guidelines which define limits of client confidentiality, and which properly protect the rights of HIV+ persons to confidentiality in their dealings with AIDS organizations." — *Resolution from the 2000 CAS PLWHIV/AIDS Forum*

> "Whereas the non-disclosure of HIV status in certain circumstances is now a criminal offense;
>
> Be it resolved that CAS, in cooperation with the Canadian HIV/AIDS Legal Network, if possible, continue to undertake all efforts to limit the negative effects of the *Cuerrier* decision on PLWHIV/AIDS on prevention, care, treatment and/or support efforts." — *Resolution from 2000 CAS Annual General Meeting*

But accurate and understandable information about HIV disclosure and criminal law is hard to wrestle out of complex legal decisions like ***Cuerrier*** and ***Williams***. It may not be possible to give a client clear answers to his or her questions. People who work in community based organizations may also be faced with competing moral and legal duties where they know a client who has not disclosed his or her HIV status is engaging in high-risk behaviours. What should the worker (or volunteer) do in this situation? What legal obligations does the worker have to the client or to the client's sex or drug injecting partner(s)? Can the worker be held criminally responsible or sued civilly for disclosing or not disclosing the client's HIV status?

HIV disclosure is also a difficult and challenging issue for EDs and CBAO Boards of Directors. **EDs and Boards are ultimately responsible for the policies and procedures of their organization, for ensuring that clients receive high quality services, and for supporting staff and volunteers in their work. They need to take a leadership role in tackling the difficult legal and ethical issues related to disclosure of HIV status.** EDs and Boards can accomplish this by:

- ensuring that staff, volunteers and clients have accurate information about their legal and ethical responsibilities;
- engaging in open and honest discussion and a policy development process that includes Board members, EDs, staff, volunteers and clients; and
- putting in place policies and guidelines about client counselling, client confidentiality and record keeping.

Disclosure of HIV Status After *Cuerrier*: Resources for CBAOs

PHAs and CBAOs called for resources to help them address the difficult issues raised by disclosing a client's HIV status. The Canadian HIV/AIDS Legal Network's report, *After Cuerrier: Canadian Criminal*

Why the Ontario Advisory Committee on HIV/AIDS (OACHA) Resources Were Developed

In response to the Supreme Court's decision in the *Cuerrier* case, Ontario's Chief Medical Officer of Health distributed a memorandum to all Medical Officers of Health (MOH) regarding the impact of the ruling on public health practices in Ontario. The Chief Medical Officer directed all public health staff conducting pre- or post-test HIV counselling to advise people "to disclose and not to lie about their HIV status to all sexual partners." The memorandum implied that HIV-positive people must disclose their status to **all** sexual partners regardless of the risk associated with the sexual activity in question. Clearly the Chief Medical Officer's memorandum went well beyond the obligation to disclose set out in the ***Cuerrier*** decision (i.e. HIV-positive people must disclose where there is a "significant risk" of HIV transmission).

In response to the memorandum, the Ontario Advisory Committee on HIV/AIDS (OACHA) identified the need for comprehensive guidelines on disclosure of HIV-positive status for all frontline service providers conducting pre- or post-test HIV counselling, or ongoing counselling of persons living with HIV. In 2002, the Ontario Advisory Committee on HIV/AIDS (OACHA) released four documents:

- Disclosing Your HIV Positive Status (an information sheet for PHAs)
- HIV Disclosure Counselling Guidelines
- Guidelines on Confidentiality of Personal Health Information
- Disclosure of HIV-Positive Status to Sexual and Drug-Injecting Partners: A Resource Document

These four documents, along with the Canadian HIV/AIDS Legal Network's *After Cuerrier: Canadian Criminal Law and the Non-Disclosure of HIV-Positive Status* (1999) and criminal law info sheets are the foundation of this Resource Guide.

Law and the Non-Disclosure of HIV-Positive Status (1999) and the CAS/Legal Network criminal info sheets provide accurate information about HIV disclosure and the legal issues involved. They also identify the difficulties and challenges facing community based AIDS organizations in Canada after the ***Cuerrier*** decision. Yet existing resources do not provide, in clear and plain language, information in a form that meets the diverse needs of CBAOs. Nor do they provide the type of resources that CBAOs may need to develop policies, practices and guidelines for their staff and volunteers. This was not what they were designed to do. Consequently, the community formally requested further information and resources through the CAS PLWHIV/AIDS Forum and AGM resolutions process in the year 2000.

In response, CAS formed a partnership with the Canadian HIV/AIDS Legal Network and the AIDS Coalition of Nova Scotia (ACNS). Funding from Health Canada's Canadian Strategy on HIV/AIDS was obtained to develop or adapt relevant information, analysis, policies and guidelines regarding HIV disclosure, counselling and confidentiality issues arising as a result of the ***Cuerrier*** decision.

A community advisory committee was established to provide direction to the project. Five members represent each region of the country [Bob Leahy, René Légaré, Michael Sobota, Carl Bognar, Jane Underwood]. The committee also includes one representative from CAS [Anna Alexandrova, National Program Consultant], the Legal Network [Glenn Betteridge, Senior Policy Analyst] and ACNS [Robert Allan, Executive Director].

Thank You

This project would not have been possible without the members of the community advisory committee (named above), the participants at three workshops where the project received community input, ACNS, Health Canada, Jane Allen (who facilitated the Halifax workshop), and Greg Garrison (who commented on the draft Resource Guide). Thank you all.

Thanks also to the AIDS Committee of Toronto, HIV/AIDS Regional Services, and the OACHA for giving permission to use policies, guidelines and other documents they developed.

Disclosure of HIV Status After *Cuerrier*

2 HIV Disclosure is a Human Rights Issue

This section of the Resource Guide can be used to:

- Learn why HIV disclosure is a human rights issue for people living with HIV/AIDS (PHAs).
- Understand the difference between HIV disclosure and contact tracing (also known as partner counselling and partner notification).
- Get insight into why HIV disclosure is difficult for many PHAs and what this means for counselling.

Health, Human Rights and HIV Disclosure After *Cuerrier*

Positive, rights-based responses to HIV/AIDS can successfully reduce the transmission of HIV and lessen the negative impact of HIV/AIDS on people and communities. The Supreme Court's judgments in the ***Cuerrier*** and ***Williams*** cases have criminalized sex involving significant risk of HIV transmission. By doing so, the Court may have unintentionally contributed to the stigma and discrimination that PHAs experience and may have undermined efforts to reduce HIV transmission.

Although we may not like or agree with the Supreme Court's judgments in the ***Cuerrier*** and ***Williams*** cases, they are the law until the Supreme Court (or Parliament) decides otherwise. So, we must respond to these decisions. Our responses must be guided above all by a concern for the health and human rights of people living with and vulnerable to HIV/AIDS.

What does health have to do with HIV disclosure? According to the World Health Organization (WHO), **health** is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. The goal of client counselling in the context of HIV disclosure is to promote client health. The closer PHAs are to this state of complete physical, mental and social well-being, the more likely they are to feel comfortable disclosing their HIV status in situations where they can enjoy the positive benefits of disclosure. As a result, counselling about HIV disclosure issues can contribute to the promotion of public health.

What do human rights have to do with HIV disclosure? From a **human rights perspective**, people are entitled to enjoy the conditions that would enable them to realize their health and well-being. This means that under international law, governments are obliged to respect, protect, and fulfill the rights of people. The animating principle of human rights is that every human being deserves to be **treated with dignity**. And while community-based organizations are not part of government, they should strive to fulfil the animating principle of human rights by treating all clients with dignity. CBAO programs (including counselling), based on human rights (right to privacy and highest attainable standard of health) and legal and ethical principles (confidentiality and informed consent), serve to lessen the adverse impact of HIV/AIDS on individuals and communities. In this way, health and human rights complement and mutually reinforce each other.

Disclosure is Complex

It can be extremely difficult for a PHA to disclose his or her HIV status. Any time a person discloses intimate details about his or her personal life, the body, mind and soul are engaged. Disclosing intimate personal information may involve thoughts, memories, feelings, and sensations. People faced with a stressful situation may remember other stressful situations, feel scared or feel like "running away", their heart may beat faster, or they may feel sick to their stomach. Disclosing one's HIV status to a sexual or injection drug partner mean talking honestly about sex, sexual orientation, sexual acts, drug use, disease and death. All of these are taboo subjects that are very difficult to talk about openly and honestly in most if not all societies and communities.

Even for the most self-affirming, self-confident person, these are difficult subjects to talk about. Vulnerabilities surface: self-image, self-perception and self-esteem are all involved. Counsellors need to be aware of all the powerful psychosocial factors that influence a person's decision to disclose or not disclose his or her HIV-positive status, including the fear of rejection, stigma, discrimination, violence and death.

Disease, Stigma and Marginalization

In our society, many people are reluctant to confront their own mortality because people fear disease and death. As a result, stigma is often associated with having any disease, particularly a life-threatening disease that can be passed from person to person. Discrimination against PHAs is common because HIV infection is often associated with particular sexual and drug use activities or with marginalized groups. Disclosure can expose PHAs directly or indirectly to discrimination in housing, employment

and access to health and social services. It can also lead to rejection by family, friends and community, and even violence. HIV disproportionately affects individuals who are already marginalized (such as gay men, injection drug users, Aboriginal people, and immigrants from countries with high rates of HIV infection). These people risk being further marginalized if they disclose their HIV-positive status.

Several studies have shown that fear of violence can have a strong impact on the decision to disclose or not, particularly amongst some HIV-positive women who fear potential reactions of their male sexual or drug-injecting partners.[1] Social exclusion and isolation can also play a role. Several studies of gay and bisexual men have demonstrated that internalized homophobia, isolation from the gay community, lack of acculturation to the majority culture and being "in the closet" can have a negative impact on some men's decision to disclose to sexual partners.[2, 3, 4]

The Timing of Disclosure

The ability to disclose one's HIV-positive status can be related to the degree to which an individual has accepted his or her HIV diagnosis. It is often most difficult to disclose soon after diagnosis, when a person is grappling with the initial impact of his or her seropositivity. In a 1998 study of homosexual and bisexual men, researchers found that initially after an HIV diagnosis, most of the men were reluctant and fearful of disclosing their HIV-positive status to others. They used this period as an opportunity to come to terms with their diagnosis before having to contend with the reactions of others. After this phase, there was evidence that disclosure was increasingly used as a mechanism for coping with the disease. Disclosure was used to increase both practical and emotional support, to share responsibility for sex, and to facilitate self-acceptance.[5]

A person's ability to disclose his or her HIV status can also be affected by the physiological and psychological changes brought on by sexual arousal, drug use or drug addiction. The release of chemicals in the body during erotic arousal can change perception, cognition and boundary setting. An intense pre-orgasmic state may strongly impact a person's ability to disclose. Both the psyche and the body are in harmony and focused on building sensuality and not necessarily on rational or ethical thoughts. People who use drugs may also experience the same type of blurring of their rational and ethical vision. Disclosure may be easier before intense erotic arousal or when the physiological and psychological need for drugs is not so great.

The Context of Disclosure

Disclosure may be easier or more difficult depending on the context in which it takes place. For example, a PHA who injects drugs daily may be faced with practical barriers and fears about disclosure arising out of his or her context and environment. If she discloses her HIV status to people with whom she shares injection drug equipment, she will likely face discrimination, and the potential loss of his or her source of drugs and possible exclusion from his or her network of contacts and partners.

In many cases, due to fears of rejection, disclosure to potential sexual partners may be more difficult than disclosure to trusted friends or family. Some reports have suggested that disclosure to potential anonymous sexual partners may be more difficult than to regular sexual partners. This may be due in part to fear of sexual rejection in a sexualized and sexually competitive environment.

In the environments where anonymous sex and injection drug use take place, serious conversations about HIV status usually do not. In these environments, people may make choices about sexual acts and injection drug use based on non-verbal disclosure signals, assumptions, or underlying physiological and psychological factors. Needless to say, it is dangerous to make assumptions about someone's HIV status. Worse still are assumptions on someone's HIV status based on their behaviour, physical "signals" or what they have not said. For example, Tariq who is HIV-negative may assume that a partner who wants to have unprotected sexual intercourse is also HIV-negative. The partner, who is actually HIV-positive, is assuming that Tariq would only have unprotected sex if he were already HIV-positive.

Disclosure in the context of a long-term or committed relationship may also be extremely difficult. Relationships may not always be based on trust, honesty, openness, safety, or good communication. A PHA may fear his or her partner's reaction. A PHA may fear losing his or her partner, children, financial security, or physical and emotional violence.

People who inject drugs may perceive little, if any, benefit from disclosing their HIV status. Studies have shown that health and social services are not designed to meet the needs of impoverished injection drug users. They often must break down the barriers created by traditional service provision in order to receive the health care services they are entitled to receive. And PHAs who are able to access treatment face a lack of support to deal with the side effects and adherence issues associated with taking HIV medications.

Legal and Ethical Obligation to Prevent HIV Transmission

In a civil society such as Canada, most people believe that **all sexually active people and people who inject drugs, whether they know their HIV status or not, have an ethical obligation to prevent the spread of HIV infection.** Practising "safer sex" and not sharing injection drug equipment that carries HIV-infected blood are two of the steps everyone can take to reduce HIV transmission.

But **ethics are not always so clear cut**. Some PHAs believe that they fulfil their ethical obligation to prevent HIV transmission to sexual and injection drug partners by disclosing their HIV status to all potential partners. Some PHAs may choose never to disclose their HIV status to potential injection drug and sexual partners, but fulfil their personal ethical obligation by taking steps to minimize the risk of HIV transmission, like condom use and cleaning injection equipment. Some PHAs may decide they are behaving ethically sharing injection equipment or having unsafe sex and not disclosing their HIV status because everyone in their community knows about the high rates of HIV infection and the risk of transmission.

In some circumstances PHAs have a **legal obligation** to disclose their HIV status. As a result of the Supreme Court decision in the ***Cuerrier*** case, PHAs who have unprotected sexual intercourse have a legal duty under the criminal law to disclose their HIV status to sexual partners before having sex. Based on ***Cuerrier*** it is also fairly clear that a PHA who injects him or herself has a legal duty to disclose his or her HIV status before sharing the needle if it has HIV-infected blood in or on it. The Canadian criminal law, HIV disclosure and the ***Cuerrier*** decision are analyzed and explained in Chapter 3 (Criminal Law).

What Counsellors Need to Know About Disclosure

PHAs Should Control Disclosure of Their HIV-Positive Status

Privacy and confidentiality are the legal and ethical foundations of the counselling relationship. Without them there can be no trust between a person living with HIV and a counsellor, and the potential benefits of counselling will be squandered. Except in narrow circumstances that must be legally and ethically justified, PHAs should decide how, when, and to whom they disclose their HIV status. The legal and ethical obligations of counsellors and CBAOs are reviewed at in Chapter 6 (Counselling and HIV Disclosure: Standards and Approaches).

The Right to Full, Active, Healthy and Self-Determined Sexual Expression

Sex is part of how people express and define themselves. PHAs are entitled to a healthy sex life. PHAs do not necessarily have to tell every sexual partner that they are infected with HIV, depending on the sexual activities they do. There are many sexual activities that pose no, negligible or a low risk of HIV transmission.

Disclosure is Not Contact Tracing

In the context of HIV infection, contact tracing is a **public health** measure designed to prevent HIV transmission and to encourage people who have been exposed to HIV to seek medical care. Contact tracing is not disclosure, but it may involve an act of disclosure. Disclosure is the act of telling or revealing (HIV status). Contact tracing is process that involves contacting the sexual or injection drug partners of a person who has a blood-borne or sexually

transmitted infection (including HIV), advising them that they have been exposed to the infection, and advising them that they should seek medical care. In the case of someone with HIV, the only partners who engaged in activities that had a real risk of transmitting HIV need to be contacted.

When a person first tests positive for HIV, a health care provider (usually a doctor or a public health nurse), will counsel that person to contact his or her sexual and injection drug partner(s). Where the person living with HIV discloses his or her HIV status to a sexual or injecting partner and advises that person to seek appropriate medical care, an act of disclosure is involved. Where a PHA is not prepared to contact his or her partners, the health care provider may contact the positive persons' partners with or with the PHA's consent, depending on the circumstances. But the health care provider must not reveal the HIV-positive person's name or any other information that would identify the HIV-positive person. However, in practice a partner who is contacted may figure out the identity of the PHA. If they do, an act of disclosure has taken place, albeit unintentionally.

Counsellors May Be Biased

Counsellors should strive to recognize their biases regarding sexual or drug-injecting behaviours in order to address them. A 1998 American study of 309 marriage and family therapists, examining factors related to counsellors' breaking confidentiality when HIV-positive clients' disclose high risk sexual behaviour, found that counsellors were more likely to breach a client's confidentiality if the counsellor was older, female, had less experience with lesbian or gay populations, was Catholic or was very religious.[6]

If they have not already done so, counsellors should reflect on whether they are biased against people who use drugs. Many CBAOs have adopted a harm reduction approach to better serve the needs of individual clients and populations who use drugs, including people who inject drugs. The harm reduction approach is a pragmatic and humanistic approach to lessen the individual and social harms associated with drug use, especially the risk of HIV infection. It reduces the harms associated with drug use by using policies and practices that safeguard the dignity and human rights of people

Adopting a Harm Reduction Approach

adapted from the International Harm Reduction Development Program (Open Society Institute), What is Harm Reduction? *1 January 2001*

Harm reduction is a pragmatic and humanistic approach to reducing the individual and social harms associated with drug use, especially the risk of HIV infection. It seeks to lessen the problems associated with drug use through methods that safeguard the dignity, humanity and human rights of people who use drugs.

This approach is based on the pragmatic acknowledgement that, despite years of trying, there are no known effective interventions for eliminating drug use or drug-related problems in any community, city, or country. In most cultures, adopting a harm reduction approach requires a shift in thinking away from deeply rooted, long-term idealistic goals of eliminating drug use.

Harm reduction does not deny the value of helping people to become drug free. It simply recognizes that for many drug users, this is a distant possibility. Recognizing the reality of drug use, harm reduction programs measure success in terms of individual and community quality of life and health, and not in relation to levels and frequencies of drug use.

In practice, harm reduction uses a range of services to achieve its goals. Needle exchanges and replacement therapy treatment (like using Methadone to replace heroin) are the two of the most effective interventions to reduce drug-related harm. These are often complemented by other supportive services for drug users such as health and drug education, HIV and STD screening, psychological counselling, and medical referrals. By providing accessible services that meet drug user needs, harm reduction programs often serve as a meaningful point of contact that can connect drug users with other community, medical, and social service resources.

From Principle To Practice: Greater Involvement of People Living With or Affected by AIDS

(GIPA) (UNAIDS, September 1999)

At its most basic, GIPA means two important things:

- recognizing the important contribution people infected or affected by HIV/AIDS can make in the response to the epidemic
- creating space within society for their involvement and active participation in all aspects of that response.

There is no substitute for direct experience, which can be considered a kind of expertise if accompanied by the ability to communicate. At its most basic, greater involvement by PHAs therefore means creating a space for individuals to:

- use their experience of living with or being affected by HIV/AIDS in the greater response to the epidemic
- give a human face and voice to the epidemic in the minds of people not directly touched by it.

In an operational sense, this involvement may (and should!) include a variety of roles at many different levels, including target audiences, contributors, speakers, implementers, experts and decision makers.

who use drugs. See the SIDEBAR/TEXTBOX "Adopting a Harm Reduction Approach" for background on the harm reduction approach.

PHAs Have a Role to Play in Policy Development

PHAs must have a real opportunity to have a say in policies and resources related to the disclosure of HIV status. PHAs live disclosure issues. They are experts on the impact disclosure has on PHAs. Taking into account the experiences and perspectives of PHAs can enrich the resource and policy development process, lead to better policies and resources. It also demonstrates the commitment of CBAOs to the greater involvement of people living with or affected by AIDS (GIPA Principle). It is up to each organization to determine how best to ensure PHA input. The SIDEBAR/TEXT BOX provides background on the GIPA Principle.

Developing Resources for Clients

The Resource Guide can be used to develop culturally and community specific information about HIV disclosure for PHAs. When developing information sheets, fact sheets, brochures and other materials, CBAOs should take into account the need for different tools based on the particular needs of different client groups. It is helpful to consider things like:

- Literacy skills
- Cultural and community practices and values
- Culturally and community appropriate language
- The need for focus testing among different client groups

An info sheet that speaks to one community may have little or no relevance for another community. In a worst-case scenario, it may offend individuals, and act as a barrier that prevents people from receiving much-needed information.

[1] Gielen, A., O'Campo, P., Faden, R., and Eke, A. "Women's disclosure of HIV status: experiences of mistreatment and violence in an urban setting," Women Health, 1997.

[2] Kennamer, J., Honnold, J., Bradford, J., and Hendricks, M. "Differences in disclosure of sexuality among African American and White gay/bisexual men: implications for HIV/AIDS prevention," AIDS Education Prevention, 2000.

[3] Ratti, R., Bakeman, R., and Peterson, J. "Correlates of high-risk sexual behaviour among Canadian men of South Asian and European origin who have sex with men," AIDS Care, 2000.

[4] Wolitski, R., Rietmeijer, C., Goldbaum, G., and Wilson, R. "HIV disclosure among gay/bisexual men in four American cities: general patterns and relation to sexual practices," AIDS Care, 1998.

[5] Holt, R., Vedhara, K., Nott, K., Holmes, J., and Snow, M. "The role of disclosure in coping with HIV infection," AIDS Care, 1998.

[6] Pais, S., Piercy, F., and Miller, J. "Factors related to family therapists' breaking confidence when clients disclose high-risks-to-HIV/AIDS sexual behaviours," Journal of Marital and Family Therapy, 1998.

Disclosure of HIV Status After *Cuerrier*

3 Criminal Law, HIV Exposure and HIV Disclosure

This section of the Resource Guide can be used to:

- Learn the basic principles of criminal law in Canada.
- Learn how the criminal law has been used to prosecute people living with HIV/AIDS (PHAs) who have had high-risk sex without disclosing their HIV status to their partners.
- Understand what the Supreme Court decided in the ***Cuerrier*** and ***Williams*** cases and what this means for PHAs.
- Understand how the criminal law regarding disclosure of HIV status applies to youth.

THE INFORMATION IN THIS CHAPTER IS NOT LEGAL ADVICE. IF YOU HAVE SPECIFIC QUESTIONS ABOUT A LEGAL PROBLEM, CONTACT A LAWYER.

Law and Crime

Law defines the rights and responsibilities of the people who live together in a society. Law also establishes, names and categorizes penalties for acts that breach rights or ignore responsibilities. It is made up of statutes (also known as "Acts") passed by legislatures, regulations made by people to whom the legislature has given the power to do so, and court decisions interpreting and applying statutes and regulations.

In Canada, crimes are established for the most part under the Criminal Code and to a lesser extent under other related laws. The federal parliament is responsible for enacting criminal law in Canada, and as such, the criminal law applies the same way across the country. A lawyer acting on behalf of the government prosecutes crimes in the name of the Queen. This lawyer is known as a **Crown Prosecutor** (sometimes referred to simply as "a Crown"). When criminal cases are reported or written about, they are often appear in the form ***R v Smith***. The "R" means "Regina", which is the Latin word for The Queen. In this example, the person named "Smith" is the person accused of the crime, also known as the defendant.

A person charged with a crime in Canada is presumed innocent until proven guilty. In order to prove that someone is guilty of a criminal offence and secure a conviction, the Crown Prosecutor must **prove that the accused committed the prohibited act (actus reus) and had the required mental element of fault (mens rea)**. The Crown Prosecutor must prove both of these elements of a crime **beyond a reasonable doubt**. Each crime has its own specific prohibited act, related to a specific mental element of fault. Typically, the mental element is the intention to bring about the consequences of the prohibited act.

Criminal Law "101"

CRIME = PROHIBITED ACT + MENTAL ELEMENT OF FAULT

For example, for the Criminal Code offence of operating a vehicle while impaired (section 253):

- the **prohibited act** is operating a vehicle while impaired with alcohol or a drug, or where the blood-alcohol level is over the legal limit
- the **mental element of fault** is intent to operate the vehicle after voluntarily consuming the alcohol or drug.

The Criminal Code clearly states that **ignorance of the law by a person who commits an offence is not an excuse for committing that offence** (section 19). This means that a person can be charged with and convicted of a criminal offence, even if he or she did not know that what he or she was doing was illegal.

Canadian Criminal Law and HIV Transmission

PHAs in Canada have been convicted for having sex where there is potential or actual transmission of HIV. In Canada there is no HIV-specific criminal law or offence that applies to the act of transmitting HIV or putting someone at risk of HIV infection. PHAs who have had unprotected sexual intercourse without disclosing their HIV status have been charged with already existing Criminal Code offences, such as:

Common Nuisance: A person who does an **unlawful act, or fails to discharge a legal duty**, thereby **endangering the lives, safety, or health of the public, or causing physical injury to any person**, commits a common nuisance. This indictable offence carries a maximum penalty of two years in prison (Criminal Code, section 180).

Administering a Noxious Thing: It is an indictable offence to administer a poison or **any other destructive or noxious thing** to a person. If the accused acts with the intent of endangering another's life, or causing bodily harm, the maximum penalty is 14 years' imprisonment. The maximum penalty is only two years' imprisonment if the intent is merely to "aggrieve or annoy" the person (Criminal Code, section 245).

Criminal Negligence Causing Bodily Harm: A person is **criminally negligent** if, in doing anything or omitting to do anything that it is their duty to do, the person **shows wanton or reckless disregard for the lives or safety of other persons**. If the

negligent conduct caused bodily harm to another person, this is an indictable offence carrying a maximum penalty of 10 years' imprisonment (Criminal Code, sections 219 and 221).

Attempted Murder: Attempting murder is an indictable offence carrying a maximum penalty of life imprisonment. A person is guilty of attempted murder if they do something with the **intent of causing another's death**, or with the **intent of causing bodily harm that they know is likely to cause death** and show reckless disregard as to whether death ensues from that act or not. It does not matter if it was actually impossible for the act to cause someone's death (Criminal Code, sections 229 and 239).

Assault, Aggravated Assault: It is an assault to **apply force intentionally** to another person without their consent. There is no legally valid consent where a person submits or does not resist by reason of **fraud**. **Common assault** carries a penalty of up to five years' imprisonment. **Aggravated assault**, where the assailant **wounds, maims, disfigures or endangers the life of the complainant**, carries a maximum penalty of 14 years' imprisonment (Criminal Code, sections 265–268).

For the actual text of the Criminal Code offences, see "Appendix — HIV Disclosure and Criminal Code Charges". For more information on the Criminal Code offences applied to HIV transmission, see the Legal Networks and CAS's Criminal Law and HIV/AIDS info sheet number 2, available at http://www.aidslaw.ca/Maincontent/infosheets.htm#inoclah

The Supreme Court of Canada's Decision in *R v Cuerrier*

The Supreme Court's 1998 decision in ***Cuerrier*** recognized that when a person who knows that he or she is HIV-positive and has unprotected sexual intercourse with someone who is HIV-negative without disclosing HIV status, he or she may be convicted of aggravated assault. So, the ***Cuerrier*** decision imposes a duty on PHAs — where sexual activity poses a **significant risk of serious bodily harm, a PHA has a legal duty to disclose their status before sex**. Failure to disclose may constitute **fraud**, which in turn makes the other person's **consent to sex legally invalid**.

Cuerrier was the first case about HIV transmission and the criminal law decided by the Supreme Court. It clarified the law for other judges, lawyers and the police. Ever since the ***Cuerrier*** case was decided, when the police charge PHAs for offences related to the non-disclosure of their HIV status, they are more likely to use the assault and common nuisance offences of the Criminal Code rather than other offences listed above.

Facts of the Case

In August 1992, a public health nurse told Cuerrier that he was HIV-positive, that he should use condoms for sex, and that he should tell his sexual partners about his HIV-positive status. Soon after, he began a relationship with a woman and their sexual relationship involved unprotected vaginal intercourse. Sometime either before or shortly after their first sexual encounter, the woman and Cuerrier discussed sexually transmitted diseases. Cuerrier told her he had tested HIV-negative several months earlier. He did not mention his recent positive test result.

A few months later, both Cuerrier and the woman had HIV-antibody tests. He tested HIV-positive; she tested HIV-negative. Both were told of Cuerrier's infection and were advised to use condoms during sex. The woman was told she would need to get tested again because she might still be in the "window period" where HIV antibodies do not show up in an HIV-antibody test. They continued having unprotected sex for 15 months. The woman later testified that: (1) she loved Cuerrier and did not want to lose him; (2) as they had already had unprotected sex, she felt she was probably already infected; (3) however, she would not have had sex with Cuerrier had she known his HIV status at the outset. At the time of Cuerrier's trial, she was HIV-negative.

Not long after Cuerrier ended the relationship with this woman, he began a sexual relationship with another woman. 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 condom was used for about five of their ten sexual encounters. The woman then discovered that Cuerrier was HIV-positive and confronted him, at which point he said he was sorry and should have told her. She was not infected.

Based on the evidence of the women, the police charged Cuerrier with two counts of aggravated assault. The trial judge acquitted him on both counts. The BC Court of Appeal agreed, saying there could be no assault because the women had consented to sex. The Crown appealed to the Supreme Court of Canada.

The Law: Aggravated Assault

The ***Cuerrier*** case was about the offence of aggravated assault under the Criminal Code. Under the Criminal Code, a person commits an **assault** when:

- **without the consent** of another person, he **applies force intentionally** to that other person, directly or indirectly
  - — Force does not have to have its ordinary, day-to-day meaning.
  - — Simply touching another person is applying force to that person for the purposes of the Criminal Code assault offence.

The Criminal Code states that **no consent is obtained** where the complainant submits or does not resist because of **fraud**. The meaning of **fraud**, and what counts as fraud for the purposes of assault is analyzed in detail below.

Under the Criminal Code, **aggravated assault involves wounding, maiming, disfiguring or endangering the life of another person**. This crime can be punishable by imprisonment for a maximum of **fourteen years** for each conviction.

The Issues Decided by the Supreme Court

The Supreme Court decided three issues in the ***Cuerrier*** case:

> Issue #1: Is a person's consent to engage in unprotected sexual intercourse vitiated (in other words, broken) by fraud where her partner knows that he is HIV-positive and either fails to disclose or deliberately deceives her about it?
>
> Issue #2: If consent is fraudulently obtained in those circumstances, can the aggravated assault offence of the Criminal Code be applied?
>
> Issue #3: Would the application of the Criminal Code undermine public health policies about HIV/AIDS?

What the Supreme Court Decided and Why

Issue #1

Is a person's **consent** to engage in unprotected sexual intercourse **vitiated (in other words, broken) by fraud** where one's partner knows that he or she is HIV-positive and either fails to disclose or deliberately deceives the other person? The Supreme Court answered "yes".

While differing over how broadly "fraud" should be defined in the law of assault, all seven of the Supreme Court judges agreed that Cuerrier's **non-disclosure of his HIV-positive status was a fraud that could vitiate his sexual partners' consent to sex**. The Supreme Court decided that there are two essential elements of fraud:

First, there must be conduct that the reasonable person would consider **dishonest**. The Court held there is no difference "between lies and a deliberate failure to disclose." Therefore, not telling a sexual partner about HIV infection can be considered "dishonest."

Second, the Crown Prosecutor must prove this dishonesty resulted in a **significant risk of serious bodily harm** to the person whose consent is being obtained by means of the dishonesty. The Court accepted that infection with HIV is a serious bodily harm, and that unprotected sexual intercourse certainly presents a "significant" risk.

Issue #2

If the **consent to unprotected sexual intercourse is obtained by fraud**, can the HIV-positive person be convicted of **aggravated assault** under the Criminal Code? The Supreme Court answered "yes".

The Supreme Court stated that in order to secure a conviction of aggravated assault the Crown Prosecutor most prove beyond a reasonable doubt two things: (1) that the consent to unprotected sexual intercourse was obtained by fraud; **and**

(2) the person would not have consented to sexual intercourse if the HIV-positive person had disclosed his status.

Issue #3
Would the application of the **Criminal Code undermine public health policies** about HIV/AIDS? The Supreme Court answered "no".

The Supreme Court judges stated that criminal law has a role to play in achieving the public health goal of stopping HIV transmission. In their view, the criminal law can deter PHAs from putting the lives of others at risk. It can also protect the public from individuals who refuse to comply with public health orders to abstain from high-risk activities. The criminal law can be effective where public health laws fail because of its penalties.

A majority of the judges rejected the argument that criminalization will deter marginalized communities from getting tested. They also rejected the argument that criminalizing non-disclosure of HIV status will undermine the educational message that everyone is responsible for protecting himself or herself against HIV infection.

At the end of the day, the Supreme Court placed the primary responsibility for avoiding the risk of HIV transmission upon PHAs, whether we agree with the Court or not.

Significant Risk of Serious Bodily Harm and the Safer Sex "Defence"

The phrase "significant risk of serious bodily harm" is not defined in the ***Cuerrier*** decision or the Criminal Code. But it is central to the Supreme Court's reasoning about whether or not an HIV-positive person had a duty to disclose his HIV status before sexual intercourse. **Where there is a significant risk of serious bodily harm, there is a duty on the HIV-positive person to disclose his or her HIV status.**

> "Without disclosure of HIV status, there cannot be 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." — *Mr. Justice Cory, Supreme Court of Canada*

> **The Safer Sex Defence** "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 [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 [aggravated assault] section [of the Criminal Code] can be satisfied. In the absence of those criteria, the duty to disclose will not arise." [emphasis added] — *Mr. Justice Cory, Supreme Court of Canada.*

Therefore, it stands to reason that if a person living with HIV does not place his sexual partner at a significant risk of serious bodily harm, he will not be found guilty of aggravated assault. **Six of seven judges of the Supreme Court suggested that there might be a safer sex defence to a charge of aggravated assault if a condom is properly used.** An HIV-positive person may not have a legal obligation to disclose his or her HIV status to a sexual partner if a condom is properly used during sexual intercourse. **However, since no court has decided whether a person can be found "not guilty" of aggravated assault based on the safer sex defence, it is not the law.**

For More Information on the *Cuerrier* Case …

The full text of the Supreme Court's ***Cuerrier*** decision is available online at <www.droit.umontreal.ca/doc/csc-scc/en/index.html>.

For more explanation and analysis of the ***Cuerrier*** decision, see:
The Canadian HIV/AIDS Legal Network's report *After Cuerrier: Canadian Criminal Law and the Non-Disclosure of HIV-Positive Status* (1999), available at http://www.aidslaw.ca/Maincontent/issues/criminallaw/finalreports/cuerrier/tofc.htm; or
The Legal Network's and CAS's Criminal Law and HIV/AIDS info sheets, numbers 1, 7 and 8, available at http://www.aidslaw.ca/Maincontent/infosheets.htm#inoclah.

The Supreme Court of Canada's Decision in *R v Williams*

In 2003, the Supreme Court decided the ***Williams*** case. The Court found a person who knows that he or she is HIV-positive **cannot be convicted of aggravated assault for having unprotected sexual intercourse without disclosing HIV status where there is a reasonable doubt about whether the other person was HIV-positive at the time they had intercourse.**

Facts of the Case

Harold Williams began an 18-month relationship in June 1991 with a woman who eventually went to the police and had him charged when she found out she was HIV-positive. They had unprotected sex on numerous occasions. On 15 November 1991, Williams tested HIV-positive and the woman tested negative a few days later. But the Court found it likely that she had already been infected with HIV at that point, but had not tested positive because she was in the "window period" between infection and seroconversion.

After Williams learned that he was HIV-positive, the relationship continued for another year and included unprotected sex. He did not tell his partner that he was HIV-positive although two doctors and a nurse counselled him on three different occasions about HIV, its transmission, safer practices, and his duty to disclose his HIV status to sexual partners.

The relationship ended in November 1992. In April 1994, William's former partner learned that she was HIV-positive. In the court case, both Williams acknowledged that she would never have had unprotected sex with him had she known he was HIV-positive. He admitted that he infected the complainant with HIV. The prosecution admitted that it is quite possible that Williams infected the complainant before learning of his HIV-positive status.

Williams was charged with aggravated assault and common nuisance. At trial court, he was convicted of both offences. The Court of Appeal of Newfoundland and Labrador confirmed the conviction for common nuisance. But the Court of Appeal substituted a conviction of attempted aggravated assault for the charge of aggravated assault.

The Law: Attempted Aggravated Assault

A person can be convicted of an **attempted** crime where not all of the elements of a Criminal Code offence are proven beyond a reasonable doubt, but the evidence shows that the person attempted to commit the offence (section 24). For example, a gunman who shoots a person who he thinks is sleeping cannot be convicted of murder if the victim had already died of natural causes. But the gunman can be convicted of attempted murder.

Under the Criminal Code, the offence of aggravated assault requires that the assault **endanger the life of the complainant**.

The Issue Decided by the Supreme Court

Seven judges of the Supreme Court heard the ***Williams*** case, and rendered a unanimous judgment. The Supreme Court decided one issue:

1. Can a person who fails to disclose his or her HIV-positive status be convicted of an aggravated assault endangering life as a result of having unprotected sexual intercourse with someone who may have been HIV-positive at the time of the alleged assault?

What the Supreme Court Decided and Why

The Supreme Court found that it was "likely" that the woman was already infected with HIV, through unprotected sex with Williams, before he found out that he was HIV-positive. Therefore, the prosecution did not prove beyond a reasonable doubt that Williams had endangered the complainant's life by exposing her to HIV, so he could not be convicted of aggravated assault.

However, the Supreme Court found that Williams was guilty of the Criminal Code offence of **attempted aggravated assault**. He knew he was HIV-positive, had the necessary intent to commit the assault and acted to carry out that intent.

Three Other Significant Points in the *Williams* Decision

Although not central to the result in Williams' situation, the Supreme Court raised (but did not decide for sure) three other important points that

may have serious consequences for HIV-positive people:

- **A person might be convicted of (attempted) aggravated assault even if he or she does not know for certain that he or she is HIV-positive (based on a medical test or diagnosis).** All the Crown Prosecutor would have to show is that the person acted **recklessly**. The Court said if a person **becomes aware of a risk that he or she has contracted HIV**, but nevertheless has unprotected sex **that creates a risk of HIV transmission** without disclosure to his or her partner, recklessness is established. This means that people who think that they may be HIV-positive have a legal duty to tell their sexual partners this.
- **A person might be convicted of (attempted) aggravated assault even if his or her sexual partner is already HIV-positive.** Whether or not a charge of aggravated assault can be proven will depend upon the medical and scientific evidence in each case about whether or not "re-infection" with HIV endangers the person's life. This means that an HIV-positive person has a legal duty to disclose his or her HIV status before having sex that has a significant risk of HIV transmission, even to a partner he or she knows is HIV-positive. A person who is aware of the risk that he or she is HIV-positive would have the same legal obligations.
- **Although the Supreme Court did not analyze the issue, it agreed with William's conviction on the charge of common nuisance.** So the Supreme Court seems to accept that it is appropriate to use the Criminal Code offence of common nuisance in cases of non-disclosure of HIV status.

For More Information on the *Williams* Case: …

The full text of the Supreme Court's ***Williams*** decision is available online at http://www.lexum.umontreal.ca/csc-scc/en/rec/html/2003scc041.wpd.html

For more explanation and analysis of the ***Williams*** decision, see the Canadian HIV/AIDS Legal Network's *Note on R v Williams (criminal liability for HIV exposure), 18 September 2003*, available at http://www.aidslaw.ca/Maincontent/issues/criminallaw/williams-comment.htm

Judging Significant Risk of HIV Transmission

The phrase **significant risk of serious bodily harm** was not clearly defined by the Supreme Court in either the ***Cuerrier*** or ***Williams*** cases. What the Supreme Court did state was that HIV infection is a serious bodily harm, and that a single act of unprotected sexual intercourse carries a significant risk of HIV transmission. As other cases arise, judges will have to decide what other activities can lead to an (attempted) aggravated assault conviction because they carry a significant risk of serious bodily harm (ie: of HIV transmission that causes harm).

The Canadian AIDS Society *HIV Transmission Guidelines for Assessing Risk* (3rd edition, January 1999) is the primary community resource in Canada regarding levels of risk of HIV transmission. The CAS Transmission Guidelines rate the degree of risk involved in sexual, injection and piercing activities, breast-feeding and certain medical procedures (artificial insemination, blood transfusions and childbirth).

The CAS Transmission Guidelines rate activities on a scale — from **no risk**, to **negligible risk**, to **low risk**, and finally to **high risk**. This rating scale is based on the **likelihood of transmission** (based on the principles of transmission and laboratory evidence like viral load) and the **evidence** of transmission associated with each activity (based on documented evidence of HIV transmission from studies and reports). The CAS Transmission Guidelines also identifies barriers that can reduce risk (such as condoms) and biological and other factors that can increase risk (such as damage to the lining of the vagina or sexually transmitted infections).

According to CAS Transmission Guidelines, the following activities carry a **high risk** of HIV transmission:

- Insertive or receptive penile-vaginal intercourse without a condom.
- Insertive or receptive penile-anal intercourse without a condom.
- Sharing a needle or syringe.
- Inserting a sex toy into the anus or vagina after a sexual partner has inserted it in her vagina or anus, or his anus.

We can assume that a court would decide that these **high risk** activities carry a **significant risk of serious bodily harm** (the words used by the Supreme Court in the ***Cuerrier*** decision).

Because there is a significant risk of serious bodily harm associated with high risk activities, a PHA has a legal duty under criminal law to disclose his or her HIV status before engaging in them.

For more information about HIV transmission and the legal risks associated with common activities, see the table at the end of Chapter 4 (What PHAs Need to Know About the Criminal Law), under the section "Activity, Risk of HIV Transmission, Duty to Disclose and Criminal Offence: All in a Table". The table lists sexual and drug injecting activities. For each activity the table sets out the risk of HIV transmission associated with the activities, whether or not there is a duty to under the criminal law to disclose HIV status (or risk of being HIV-positive), and the criminal offence that could be applied if a person does not disclose his or her HIV status (or risk).

Two Other Significant Criminal Law Cases

R v Edwards: The Court's decision in this case is not significant although an acknowledgement by the Crown Prosecutor is. Edwards, who was HIV-positive, engaged in oral sex and anal sex with a sexual partner. Both agreed that condoms were not used for oral sex. They disagreed on whether condoms were used for anal sex. The Crown Prosecutor acknowledged that unprotected oral sex between two men is a low risk activity and as a result Edwards could not be charged with aggravated assault. The Crown Prosecutor's acknowledgement **is not law and is not binding on other Crown Prosecutors**. However, it does indicate how Crown Prosecutors may analyze complaints to police involving oral sex.

R v Jones: The police laid two charges of aggravated assault against Jones because he was **Hepatitis C** positive and did not tell two men before having unprotected sexual intercourse with them. The judge found Jones not guilty of aggravated assault. He reached this verdict because the medical evidence demonstrated that Hepatitis C is not a sexually transmitted disease and the risk of contracting it through sexual intercourse is low (in the range of 1% to 2.5%). Therefore, Jones' failure to tell his partners was not fraud, and did not vitiate their consent to unprotected sexual intercourse.

Both these cases were decided after the Supreme Court decided the ***Cuerrier*** case, but before it decided the ***Williams*** case.

Cuerrier and *Williams* Do Not Impose Criminal Liability on Counsellors

Neither the ***Cuerrier*** or ***Williams*** decision means that counsellors must inform the police if a client does not disclose prior to engaging in high risk rex or injection drug use. **Counsellors have no legal obligation under the Criminal Code or as a result of the *Cuerrier* decision to provide information to the police about an HIV-positive client's potentially criminal behaviour.** Counsellors cannot be criminally charged for failing to warn the sex or injection drug partners of a client that the client is HIV-positive, regardless of the fact that the counsellor knows the client and partner are engaged in high risk activities.

In the case of **children in need of protection**, counsellors have a legal duty under child welfare law to report the situation to child protection authorities, but **not** to the police.

However, counsellors **may** face civil law suits if they don't take steps to prevent a client from harming another person. See Chapter 8 (Civil Liability Issues

for PHAs and CBAOs) for more information about this issue.

Counsellors have a **legal obligation to keep client information confidential**. However, a counsellor may be required under a court order or search warrant to provide the police with information about a client. The counsellor's and community based AIDS organization's (CBAO) options when faced with a court order or search warrant are discussed in Chapter 7 (Client Confidentiality and Record-Keeping).

HIV-Positive Youth and the Criminal Law

Criminal law regarding HIV disclosure applies to HIV-positive youth in Canada as well. HIV-positive youth and the people who counsel them need to know what duties the criminal law places on youth in the disclosure of their HIV status. They also need to know how the criminal law may treat youth if they are charged with an offence for not disclosing their HIV status.

The Youth Criminal Justice Act (YCJA)

Youth can be charged with offences under the Criminal Code (and other criminal laws), including assault and aggravated assault. But a special system of dealing with criminal charges applies to youth. This system is set out in the Youth Criminal Justice Act (YCJA). The YCJA came into force on 1 April 2003, replacing the Young Offenders Act (YOA).

Under the YCJA, a **young person** is someone who is or appears to be **twelve years old or older, but is less than eighteen years old**. Young person also includes anyone who is charged under this Act with having committed an offence while he or she is older than 12 but less than 18 years old.

The YCJA is different in many ways from the criminal justice system for adults under the Criminal Code. The YCJA establishes:

- enhanced protections throughout the process to ensure that the youth's rights are safeguarded;
- alternatives to prosecution for criminal charges, including cautions, warnings, and penalties agreed to by the youth;
- as a general rule, a ban on the publication of any information that would identify a young person dealt with under the act;
- as a general rule, a maximum sentence of three years; and
- the disposal or destruction of criminal and court records after the passage of a specified period of time.

Adult Sentences for Certain Offences for "Older" Young Persons

Under the old law (the YOA), a young person who was 14 years of age or older could be transferred to an adult court under certain circumstances and, if convicted there, receive an adult sentence. **Under the YCJA, a young person can no longer be transferred to an adult court**. However, in certain circumstances, and only after a finding of guilt, the court can consider whether an adult sentence is appropriate. An **adult sentence** means any sentence that could be imposed on an adult who has been convicted of the same offence.

Under the YCJA, certain criminal offences are defined as **presumptive offences**. In fact, the presumption does not relate to the offence itself, but to the sentence that can be handed down where a youth is found guilty of an offence. The Crown Prosecutor can apply to the youth justice court to have an **adult sentence** handed down if the young person is found guilty of:

- first or second degree murder;
- attempt to commit murder;
- manslaughter;
- aggravated sexual assault; and
- a **serious violent offence** for which an adult is liable to imprisonment for a term of more than two years.

The YCJA sets the minimum age for presumptive offences at 14 years of age or older. However, each province and territory can increase the minimum age to 15 or 16 years of age. Under the YCJA, a judge can only impose an adult sentence where a

youth sentence would not be of sufficient length to hold the young person accountable, bearing in mind that the accountability of the young person must be consistent with the greater dependency of young persons and their reduced level of maturity.

Where the Crown Prosecutor intends to seek an adult sentence, he or she must notify the youth and youth justice court. **The youth justice court must hold a hearing and decide whether or not it is appropriate to impose an adult sentence.**

Cuerrier, *Williams* and Presumptive Offences

The assault or attempted assault offences in the ***Cuerrier*** and ***Williams*** cases qualify as **presumptive offences** under the YCJA. Each carries a potential sentence of more than 2 years. In addition, the broad category of **serious violent offence** in the YCJA includes any offence in the commission of which a young person causes or attempts to cause serious bodily harm. Based on the ***Cuerrier*** case, there must be a **significant risk of serious bodily harm** in order to find someone guilty of aggravated assault. The Criminal Code offence of common nuisance is not a presumptive offence, since the maximum sentence is 2 years.

Consequently, young people who are 14 to 17 years of age **may** face adult sentences if they are found guilty of an assault related to the non-disclosure of their HIV status to a sexual or injection drug partner. It will be up to the youth justice court to decide if a youth sentence or an adult sentence is appropriate.

Disclosure of HIV Status Without Consent Under the YCJA

Young persons who are HIV-positive face the possible disclosure of their HIV status under the YCJA, even when they do not give their consent. There are four ways that the YCJA may lead to the disclosure of a young person's HIV-status without his or her consent.

First, the parents (or a relative or another adult) must be informed of measures or proceedings involving their children. The police have a duty to inform parents when a young person is arrested and to inform them of the reason for the arrest, including the charge. If the court orders a medical or psychiatric report, a copy of the report must be given to the young person's parents. Some youth may not tell their parents that they are HIV-positive, for any number of reasons. Where a young person is charged with a criminal offence related to non-disclosure of HIV status, their HIV status will probably be disclosed to his or her parents either directly or indirectly.

Second, a youth's HIV status may be disclosed without his or her consent to:

- ensure compliance with the terms of an authorization granting leave from custody;
- ensure the safety of staff, students or other persons, or
- facilitate the rehabilitation of the young person.

In any of these circumstances someone (a youth worker, the Attorney General, a peace officer or any other person engaged in the provision of services to young persons) may disclose to another person (a professional or other person engaged in the supervision or care of a young person, including a representative of any school board or school, or any other educational or training institution) any information contained in police or court records.

Third, a media publication ban does not apply to a young person who has received an adult sentence or has received a youth sentence for a presumptive offence. The name of a young person and any other information related to a young person can be published without his or her consent.

Fourth, a youth justice court can make an order permitting any person to publish information that identifies a young person as having committed or allegedly committed an indictable offence:

- if the judge is satisfied that there is reason to believe that the young person is a danger to others, or
- the publication of information is necessary to assist in apprehending the young person.

Information and Advice

The youth criminal justice system is complex. The information in this section is intended to provide an **overview of how the YCJA may apply** to youth charged with a criminal offence related to the non-disclosure of their HIV-status in a situation that risks

transmitting HIV. For more information about the Youth Criminal Justice Act and the youth criminal justice system, go to: http://canada.justice.gc.ca/en/ps/yj/repository/index.html.

If you have specific questions about youth, the YCJA and the criminal law, consult a lawyer with expertise representing youth in the criminal justice system.

Appendix — HIV Exposure and Criminal Code Charges

Attempts

24. (1) Every one who, having an intent to commit an offence, does or omits to do anything for the purpose of carrying out the intention is guilty of an attempt to commit the offence whether or not it was possible under the circumstances to commit the offence.

(2) The question whether an act or omission by a person who has an intent to commit an offence is or is not mere preparation to commit the offence, and too remote to constitute an attempt to commit the offence, is a question of law.

Common Nuisance

180. (1) Every one who commits a common nuisance and thereby

(a) endangers the lives, safety or health of the public, or

(b) causes physical injury to any person, is guilty of an indictable offence and liable to imprisonment for a term not exceeding two years.

(2) For the purposes of this section, every one commits a common nuisance who does an unlawful act or fails to discharge a legal duty and thereby

(a) endangers the lives, safety, health, property or comfort of the public; or

(b) obstructs the public in the exercise or enjoyment of any right that is common to all the subjects of Her Majesty in Canada.

Attempted Murder

239. Every person who attempts by any means to commit murder is guilty of an indictable offence and liable

(a) where a firearm is used in the commission of the offence, to imprisonment for life and to a minimum punishment of imprisonment for a term of four years; and

(b) in any other case, to imprisonment for life.

229. Culpable homicide is murder

(a) where the person who causes the death of a human being

(i) means to cause his death, or

(ii) means to cause him bodily harm that he knows is likely to cause his death, and is reckless whether death ensues or not;

(b) where a person, meaning to cause death to a human being or meaning to cause him bodily harm that he knows is likely to cause his death, and being reckless whether death ensues or not, by accident or mistake causes death to another human being, notwithstanding that he does not mean to cause death or bodily harm to that human being; or

(c) where a person, for an unlawful object, does anything that he knows or ought to know is likely to cause death, and thereby causes death to a human being, notwithstanding that he desires to effect his object without causing death or bodily harm to any human being.

Criminal Negligence Causing Bodily Harm

221. Every one who by criminal negligence causes bodily harm to another person is guilty of an indictable offence and liable to imprisonment for a term not exceeding ten years.

Administering Noxious Thing

245. Every one who administers or causes to be administered to any person or causes any person to take poison or any other destructive or noxious thing is guilty of an indictable offence and liable

(a) to imprisonment for a term not exceeding fourteen years, if he intends thereby to endanger the life of or to cause bodily harm to that person; or

(b) to imprisonment for a term not exceeding two years, if he intends thereby to aggrieve or annoy that person.

Assault and Aggravated Assault

265. (1) A person commits an assault when

(a) without the consent of another person, he applies force intentionally to that other person, directly or indirectly;

(b) he attempts or threatens, by an act or a gesture, to apply force to another person, if he has, or causes that other person to believe on reasonable grounds that he has, present ability to effect his purpose; or

(c) while openly wearing or carrying a weapon or an imitation thereof, he accosts or impedes another person or begs.

2) This section applies to all forms of assault, including sexual assault, sexual assault with a weapon, threats to a third party or causing bodily harm and aggravated sexual assault. 3) For the purposes of this section, no consent is obtained where the complainant submits or does not resist by reason of

(a) the application of force to the complainant or to a person other than the complainant;

(b) threats or fear of the application of force to the complainant or to a person other than the complainant;

(c) fraud; or

(d) the exercise of authority

(4) Where an accused alleges that he believed that the complainant consented to the conduct that is the subject-matter of the charge, a judge, if satisfied that there is sufficient evidence and that, if believed by the jury, the evidence would constitute a defence, shall instruct the jury, when reviewing all the evidence relating to the determination of the honesty of the accused's belief, to consider the presence or absence of reasonable grounds for that belief.

266. Every one who commits an assault is guilty of

(a) an indictable offence and is liable to imprisonment for a term not exceeding five years; or

(b) an offence punishable on summary conviction.

268. (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.

(3) For greater certainty, in this section, "wounds" or "maims" includes to excise, infibulate or mutilate, in whole or in part, the labia majora, labia minora or clitoris of a person, except where

(a) a surgical procedure is performed, by a person duly qualified by provincial law to practise medicine, for the benefit of the physical health of the person or for the purpose of that person having normal reproductive functions or normal sexual appearance or function; or

(b) the person is at least eighteen years of age and there is no resulting bodily harm.

(4) For the purposes of this section and section 265, no consent to the excision, infibulation or mutilation, in whole or in part, of the labia majora, labia minora or clitoris of a person is valid, except in the cases described in paragraphs (3)(a) and (b).

Full Offence Charged, Attempt Proven

660. Where the complete commission of an offence charged is not proved but the evidence establishes an attempt to commit the offence, the accused may be convicted of the attempt.

Disclosure of HIV Status After *Cuerrier*

4 What PHAs Need to Know About the Criminal Law

This section of the Resource Guide can be used to:

- Reinforce your understanding of the criminal law regarding HIV disclosure.
- Analyse how criminal law affects counselling practice and the information given to people living with HIV/AIDS (PHAs).
- Counsel PHAs about whether or not they have a duty to disclose their HIV status when having sex or sharing injection drug equipment.
- Develop information sheets for PHAs. An example of an information sheet is included at the end of the chapter.

THE INFORMATION IN THIS CHAPTER IS NOT LEGAL ADVICE, IT IS GENERAL LEGAL INFORMATION. IF YOU ARE UNSURE OF THE SPECIFIC INFORMATION YOU SHOULD GIVE TO A PARTICULAR CLIENT, GET ADVICE FROM A LAWYER.

The Law is Not Clear … So you can't always give definite answers

Disagreeing with the law or not knowing the law is not a defence to criminal charges. It will not prevent a person from being convicted. So it is important that PHAs know the potential criminal consequences of their sexual and injection drug activities. HIV-positive mothers should also be aware of how the criminal law and other laws can potentially treat the risk of mother-to-child transmission.

The information in this chapter is based on an analysis of:

- Criminal Code
- Supreme Court decisions in ***R v Cuerrier*** and ***R v Williams***
- other court decisions
- Canadian AIDS Society *HIV Transmission Guidelines for Assessing Risk* (3rd edition, January 1999)

Based on the *Cuerrier* decision, it is clear that a person who knows that he or she is HIV-positive has a legal duty to disclose his or her HIV status before:

- **having unprotected sexual intercourse (vaginal or anal)**
- **injecting a partner with a needle he or she has used to inject him or herself**

People should be counselled that courts have not decided how the criminal law applies to HIV transmission in other circumstances. The law is not clear. There are no absolutely clear, 100% certain answers.

As it stands, we can only make **informed guesses** about whether or not people living with HIV have a legal duty to disclose their HIV status before engaging in other sexual and injection drug activities. These guesses are informed by the Criminal Code, the Supreme Court's reasoning in the ***Cuerrier*** and ***Williams*** cases, other decided cases and what medical science tells us about the risk of HIV transmission.

We have virtually no legal basis to form opinions about how courts will treat behaviours that put someone at risk of Hepatitis C transmission. So we cannot give people living with Hepatitis C much in the way of useful information about disclosure issues and the criminal law. That is why this Guide does not contain information about the criminal law and Hepatitis C transmission.

Sex and Disclosure

An HIV-positive client needs to know that:

- He or she has a **legal duty to disclose** his or her HIV status to sexual partners before having sex that carries a **significant risk of HIV transmission**.
  - — Insertive or reception penile-vaginal intercourse without a condom.
  - — Insertive or receptive penile-anal intercourse without a condom.
  - — Inserting a sex toy into the anus or vagina after a sexual partner has inserted it in her vagina or anus, or his anus.
- He or she **may have a legal duty to disclose** their HIV status to sexual partners before having sex that carries a significant risk of HIV transmission **even if he or she knows that his or her sexual partner is HIV-positive**.
- If he or she does not disclose their status prior to having sex that carries a significant risk of transmitting **HIV, he or she may be convicted of aggravated assault, attempted aggravated assault**, or **common nuisance** (or other criminal offences) even though his or her partner did not actually become infected with his or her HIV.
- If he or she properly uses a condom, he or she **may not** have to disclose his or her HIV status to a sexual partner before having intercourse (vaginal or anal). This is based on the so-called **safer sex defence** identified in the ***Cuerrier*** case. **But no court has accepted the safer sex defence, so it is not the law.**
- For **sexual acts other than vaginal or anal intercourse**, whether or not he or she must

disclose his or her HIV status will depend upon the risk of HIV transmission associated with the activity and whether the activity places the other person at a significant risk of serious bodily harm.

A client who is aware that there is a risk that he or she is HIV positive (but who has not received a medical diagnosis of HIV infection) needs to know that:

- He or she **may have a legal duty** to tell his or her sexual partners about the risk that he or she may be HIV-positive before having sex that carries a significant risk of HIV transmission.
  - — Insertive or reception penile-vaginal intercourse without a condom.
  - — Insertive or receptive penile-anal intercourse without a condom.
  - — Inserting a sex toy into the anus or vagina after a sexual partner has inserted it in her vagina or anus, or his anus.
- If he or she properly uses a condom, he or she **may not** have to disclose his or her HIV status to a sexual partner before having sexual intercourse (vaginal or anal). This is based on the so-called **safer sex defence** identified in the ***Cuerrier*** case. **But no court has accepted the safer sex defence, so it is not the law.**
- For **sexual acts other than vaginal or anal intercourse**, whether or not he or she must tell his or her sexual partners about the risk that he or she may be HIV-positive will depend upon the risk of HIV transmission associated with the activity and whether the activity places the other person at a significant risk of serious bodily harm.

Injecting Drugs and Disclosure

A court has not decided the question of whether an HIV-positive injection drug user has any duty towards his or her injection partners. Unlike sex, possession of street drugs is a criminal offence to begin with. A court will likely view drug use as a criminal, rather than a health issue, and not look kindly on anyone who risks transmitting HIV by sharing drug injection equipment.

The ***Cuerrier*** and ***Williams*** cases were about unprotected sexual intercourse. They were not about applying the criminal law to injection drug activities that risk transmitting HIV. **Sharing an injecting needle or syringe that has HIV-infected blood** in or on it is the **most efficient route of HIV transmission**. It carries a greater risk of transmission than unprotected sexual intercourse. Therefore, **it is safe to assume that it carries a significant risk of serious bodily harm in the eyes of the criminal law**.

What about cleaning injection equipment (not just the needle, but also the spoon, cooker, filter and cotton) with bleach? Is that not like wearing a condom because it reduces the risk of HIV transmission? A PHA who cleans injection drug equipment with bleach before sharing it **may** have a defence to a criminal charge. As a starting point, the person accused of a criminal offence would have to prove that he or she was familiar with the proper method for disinfecting equipment, and that he or she actually used that method.

What if a person living with HIV discloses her HIV status *and* properly cleans all injection drug equipment (spoon, cooker, filter, cotton, needle)? No court has decided this issue. A court might accept the argument that the person living with HIV should not be criminally convicted because the other person accepted the risk of HIV transmission and the HIV-positive person behaved responsibly.

An HIV-positive client or a client who is aware that there is a risk that he or she is HIV positive (but who has not received a medical diagnosis of HIV infection) needs to know that:

- The only **way to avoid a criminal conviction** for creating a significant risk of HIV transmission is to **never share injection equipment**.
- An HIV-positive person has **legal duty to disclose his or her HIV status** (or risk that he or she is HIV-positive) to an injection drug partner **before injecting the partner with a needle the HIV-infected person has used**.

- If he or she **does not disclose his or her HIV status** (or risk that he or she is HIV-positive) prior to injecting a partner, he or she **may be convicted of a criminal offence even though the partner did not actually become infected with HIV**. The criminal offences that may be used are aggravated assault, attempted aggravated assault, common nuisance, administering a noxious thing or criminal negligence causing bodily harm.
- He or she will **probably not be convicted of assault or aggravated assault if he or she gives a needle he or she has just used to a partner, and the partner injects him or herself**. However, he or she **may be convicted of common nuisance, administering a noxious thing or criminal negligence causing bodily harm**.
- He or she **will probably not be convicted** of a criminal offence based on HIV transmission if he or she **discloses his or her HIV status *and* cleans the injection drug equipment before injecting a partner**. Disclosure on its own or cleaning the injection gear on its own may not be enough to avoid a criminal conviction.

Breast-Feeding and Disclosure

Scientific evidence shows that HIV can be transmitted from a mother to an infant through breast milk. The precise level of risk of breast-feeding has yet to be determined. Because of the complexity of issues relating to maternal transmission, current CAS Transmission Guidelines do not classify the risk of HIV transmission through breastfeeding within the risk model (no, negligible, low or high risk). The Guidelines advise HIV-positive mothers against breast-feeding.

Once a child is born, it is recognized by law as a **person** and the criminal law and child protection laws apply. Before a child is born, the foetus is not recognized as a person in Canadian law. If the ***Cuerrier*** case is interpreted broadly, it stands for the principle that the criminal offence of assault can be applied where one person exposes another person to a significant risk of HIV infection by touching that person without consent. Therefore, an HIV-positive mother who breast-feeds her infant risks being charged with assault. **It is not clear whether or not police will criminally charge and courts will convict HIV-positive mothers who breast-feed.**

Child protection legislation, unlike criminal law, is a provincial matter. It differs from province to province (or territory to territory). However, every Canadian province or territory has a law that **imposes a legal duty on all people to report a child who is need of protection**. A child is in need of protection where he or she has **suffered, or there is a risk that he or she will suffer, physical or mental harm**. In the ***Cuerrier*** and ***Williams*** cases the Supreme Court stated that HIV infection is a serious bodily harm. The duty to disclose HIV status under criminal law is triggered where there is **a significant risk of serious bodily harm**. Under child protection laws, everyone has a duty to report **a risk of physical or mental harm** to a child.

Therefore, a CBAO staff person or volunteer has a legal duty to report an HIV-positive mother who is breast-feeding her infant(s) to child protection authorities. But there is no duty under the criminal law to report the mother to the police.

A mother (or pregnant woman) living with HIV needs to know that:

- She **may transmit HIV if she breast-feeds her infant(s)**.
- Criminal charges **may** be laid if she breast-feeds her infant(s).
- The counsellor is **required by law to report to child protection authorities** an HIV-positive mother who breast-feeds her infant(s).

Activity, Risk of HIV Transmission, Duty to Disclose and Criminal Offence: All in a Table

In *After Cuerrier: Canadian Criminal Law and the Non-Disclosure of HIV-Positive Status* the Canadian HIV/AIDS Legal Network analyzed the possibility of criminal charges being brought against PHAs for

engaging in a number of sexual and injection drug activities. The CAS Transmission Guidelines rate sexual and injection drug activities on a scale — from **no risk, to negligible risk, to low risk, and finally to high risk**. This rating is based on the **likelihood of transmission** and the **evidence** of transmission associated with each activity. The CAS Transmission Guidelines also identify barriers that can reduce risk (such as condoms) and biological and other factors that can increase risk (such as damage to the lining of the vagina, or sexually transmitted infections).

The table below is based on a legal analysis of the criminal law regarding HIV disclosure and the CAS Transmission Guidelines.

Worksheet — A

Activity	Risk of HIV Transmission	Duty under the Criminal Law to Disclose HIV Status or Risk of Being HIV Positive	Criminal Offence • Not all of the Criminal Code offences that a PHA may be charged with for engaging in activities that risk transmitting HIV are listed in the table. Only the most common or likely offences that the police or Crown Prosecutor are likely to charge a PHA with are listed.
If you are HIV positive, or are aware that you may be HIV positive, and you have …	**… the risk of transmitting HIV to the other person is …**	**Do you have a duty to disclose your HIV status or the risk you may be HIV positive?**	**If you do not disclose and you are HIV positive, you risk being charged with …**
Sex			
Vaginal intercourse (insertive or receptive) **without** a condom	High	Yes	☐ Assault ☐ Aggravated Assault ☐ Attempted Assault ☐ Attempted Aggravated Assault ☐ Common Nuisance
Vaginal intercourse (insertive or receptive) **with** a condom	Low	Unknown	☐ Assault ☐ Aggravated Assault ☐ Attempted Assault ☐ Attempted Aggravated Assault ☐ Common Nuisance
Anal intercourse (insertive or receptive) **without** a condom	High	Yes	☐ Assault ☐ Aggravated Assault ☐ Attempted Assault ☐ Attempted Aggravated Assault ☐ Common Nuisance
Anal intercourse (insertive or receptive) **with** a condom	Low	Unknown	☐ Assault ☐ Aggravated Assault ☐ Attempted Assault ☐ Attempted Aggravated Assault ☐ Common Nuisance
Oral-Genital Sex **without** a condom or barrier [mouth or tongue on the penis or vagina of the PHA]	Low	Unknown	☐ Assault ☐ Aggravated Assault ☐ Attempted Assault ☐ Attempted Aggravated Assault ☐ Common Nuisance
Oral-Genital Sex **with** a condom or barrier [mouth or tongue on the penis or vagina of the PHA]	Negligible	Probably not	☐ Assault ☐ Aggravated Assault ☐ Attempted Assault ☐ Attempted Aggravated Assault ☐ Common Nuisance
Oral-Anal Sex **without** a condom or barrier [mouth or tongue on the anus of the PHA]	Negligible	Unknown	☐ Assault ☐ Aggravated Assault ☐ Attempted Assault ☐ Attempted Aggravated Assault ☐ Common Nuisance
Oral-Anal Sex **with** a condom or barrier [mouth or tongue on the anus]	Negligible	Probably not	☐ Assault ☐ Aggravated Assault ☐ Attempted Assault ☐ Attempted Aggravated Assault ☐ Common Nuisance
Sharing sex toys [a PHA inserts a toy in her vagina/ anus, then inserted into the anus/vagina of a sex partner]	High	Yes	☐ Assault ☐ Aggravated Assault ☐ Attempted Assault ☐ Attempted Aggravated Assault ☐ Common Nuisance

Worksheet — B

Activity	Risk of HIV Transmission	Duty under the Criminal Law to Disclose HIV Status or Risk of Being HIV Positive	Criminal Offence • Not all of the Criminal Code offences that a PHA may be charged with for engaging in activities that risk transmitting HIV are listed in the table. Only the most common or likely offences that the police or Crown Prosecutor are likely to charge a PHA with are listed.
If you are HIV positive, or are aware that you may be HIV positive, and you have …	**… the risk of transmitting HIV to the other person is …**	**Do you have a duty to disclose your HIV status or the risk you may be HIV positive?**	**If you do not disclose and you are HIV positive, you risk being charged with …**
Injecting Drugs			
PHA injects him/herself with a needle or syringe and then injects a partner with the needle or syringe **without cleaning it**	High	Yes*	☐ Assault ☐ Aggravated Assault ☐ Attempted Assault ☐ Attempted Aggravated Assault ☐ Common Nuisance
** It is not clear under the Criminal Code whether a person can legally consent to being injected with a needle by someone he or she knows is HIV-positive who has just used the needle. Even if an HIV-positive person discloses his or her status to an injection drug partner, the HIV-positive person may still be found guilty of an assault (or attempted or aggravated assault).*			
PHA injects him/herself with a needle or syringe and then injects a partner with the needle or syringe **after cleaning it with bleach**	Low	Probably*	☐ Assault ☐ Aggravated Assault ☐ Attempted Assault ☐ Attempted Aggravated Assault ☐ Common Nuisance
PHA injects him/herself with a needle or syringe, **does not clean it** and provides it to a partner to use	High	Yes	☐ Common Nuisance ☐ Criminal Negligence Causing Bodily Harm
PHA injects him/herself with a needle or syringe, then **cleans it with bleach**, then provides it to a partner to use	Low	Probably	☐ Common Nuisance ☐ Criminal Negligence Causing Bodily Harm

Disclosing Your HIV-Positive Status

An Information Sheet

What does "disclosing my HIV-positive status" mean?

Disclosing your HIV-positive status means telling someone else that you are HIV-positive. Disclosing your HIV status to another person is often difficult, whether you're disclosing to a sexual partner, someone you inject drugs with, a friend, family member, employer or anyone else you decide to tell.

Can I still have sex if I have HIV or AIDS?

Yes. People living with HIV/AIDS are entitled to an active, healthy sex life. Here are some things you should consider …

Do I have to disclose my HIV status before having sex?

The Supreme Court of Canada has ruled that you must tell your sexual partner that you are HIV-positive before having anal or vaginal intercourse (fucking) without a condom because these activities are high risk for transmitting HIV.

The Supreme Court ruling ***may*** also mean that you must disclose your HIV-positive status when engaging in lower risk activities (like oral sex). Whether the ruling applies to these lower risk activities is not yet clear. Low risk sexual activities carry some risk of transmitting HIV, so it is always legally safer to disclose your HIV status to sexual partners if it is safe for you to do so. Only you can judge whether it is safe for you.

What if the person I am having sex with doesn't want to use condoms?

If your sexual partner does not want to use condoms, it is up to you to decide whether you are comfortable putting another person at risk of HIV infection. This may also mean you are putting yourself at risk for potential new infections. Your partner must make his or her decision voluntarily, without coercion. He or she must also understand the risk of HIV transmission and not be under the influence of alcohol or drugs.

If I inject drugs, do I have to disclose my HIV status to the people I inject drugs with?

If you inject drugs, it is important that you use a clean needle, syringe and other injecting equipment (such as spoons) every time. Sharing injecting equipment with another person is high risk for transmitting HIV. If you do share injecting equipment with another person, then you must first tell him or her that you are HIV-positive. If he or she decides to share injecting equipment anyway, the same rules apply as if the decision was to have sex without a condom. The person you are going to inject drugs with must make his or her decision voluntarily, understand the risk of HIV transmission and must not be under the influence of alcohol or drugs.

What is the best way to disclose my HIV status before having sex or injecting drugs?

It is usually easier to tell someone you are HIV-positive before getting ready to have sex or inject drugs. Think over what you want to say, why you want to say it, and how you want to say it so you will feel more prepared when you disclose your status.

Do I have to disclose my HIV status to people other than sexual partners or people I inject drugs with?

No. However, by disclosing your HIV status to friends or family, you can build a support network and feel less alone about being HIV-positive. Choosing the right time and place to disclose to others is important. You may feel vulnerable right after you disclose and you need to be prepared for both positive and negative reactions from the people you disclose to.

You will need to decide whether you can trust someone with the knowledge that you are HIV-positive. Telling others you are HIV-positive means you have less control over how that information is shared. Be clear with anyone you disclose to whether it is okay for them to tell other people that you are HIV-positive. Providing the people you disclose to with written information about HIV/AIDS can often be helpful.

Disclosing your HIV status to some people, such as employers or insurers, can sometimes lead to discrimination. It is important to think carefully about what might happen if you disclose your HIV status to anyone who might discriminate against you.

Is there anywhere I can go to talk about disclosing my HIV status?

Yes. Counselling is available at many community-based AIDS organizations, public health units, or HIV outpatient clinics. You may also want to talk to your doctor about any questions or concerns you might have. **You do not have to deal with this issue on your own.** To find out where you can get local help in dealing with HIV disclosure, contact the AIDS Hotline at [insert the number of your local, regional or provincial AIDS hotline].

Disclosure of HIV Status After *Cuerrier*

5 Public Health Laws

This section of the Resource Guide can be used to:

- Learn about the functions of public health laws in Canada.
- Identify the public health law that applies in your province, territory or Aboriginal community.
- Find out if the public health law in your province or territory requires reporting of cases of HIV or AIDS, permits or requires contact tracing, and protects confidential health information.
- Find out whether public health officials in your province or territory have other powers to address behaviours that risk transmitting HIV.
- Get information about public health laws and Aboriginal people.

The Purpose of Public Health Law

Public health is what we as a society do collectively to ensure the conditions in which people can be healthy.[1] **Public health law** aims to protect the health of the general public. Public health laws vary from province to province to territory. However, throughout Canada, public health laws have **three main functions:**

1. **Classify transmissible diseases** and specify rules that apply to them.
2. Place a **duty on some persons (doctors, nurses, teachers, or lab technicians) to report** known and suspected cases of infection with transmissible diseases.
3. Grant health authorities **power to protect public health**.

Contact tracing (also know as **partner counselling** or **partner notification**) is a public health measure designed to prevent HIV transmission and to encourage people who have been exposed to HIV to seek medical care. Contact tracing is a process that involves contacting the sexual or injection drug partners of a person who has a blood-borne or sexually transmitted infection (including HIV), advising that person that he or she been exposed to the infection, and advising the person to seek medical care. In the case of someone with HIV, the only partners that need to be contacted are those partners that engaged in activities that had a risk of transmitting HIV.

Use the tables at the end of this chapter to find out about contact tracing under your province or territory's public health laws and policies.

Public Health Law and Criminal Law

Preventing the transmission of HIV is primarily a public health issue. It should be handled as a matter of public health rather than criminal law as far as possible.[2] In the ***Cuerrier*** case, the Supreme Court recognized the important role of public health law in reducing HIV transmission. But the Court also recognized that public health laws alone have proved inadequate to stop the spread of HIV. In the Court's opinion, the criminal law does have a role to play both in deterring those infected with HIV from putting the lives of others at risk and in protecting the public from individuals who refuse to comply with public health orders to abstain from high-risk activities.

The *Cuerrier* decision did not change public health laws in Canada, although it has affected public health practice. People who test HIV-positive should be counselled about the possible criminal liability they face for engaging in activities that have a significant risk of HIV transmission without first disclosing their HIV status.

Provincial and Territorial Public Health Laws

Under the Canadian constitution, "health" is a large and poorly defined responsibility. It is not exclusively or specifically assigned to either the federal or the provincial levels of government. Nonetheless, the provinces and territories have passed the legislation that applies public health and communicable diseases (like HIV/AIDS). Under provincial and territorial laws, one person is given the responsibility for overseeing public health. This person, who usually is a medical doctor, is often called the Chief Medical Officer of Health or Public Health Officer.

However, provincial and territorial laws grant most public health administrative and enforcement powers to local authorities (known as local health boards, local health units, regional authorities, regional health units). Usually, the Chief Medical Officer of Health or Public Health Officer is given the authority to publish policies and procedures to direct the work of local and regional authorities. He or she may also publish guidelines on specific public health matters, or he or she may not. For example, the standards for partner notification (also known as contact tracing) programmes may be set for the whole province or standards may be left up to each local or regional health authority.

Aboriginal (First Nations, Métis and Inuit) Jurisdictional Issues

The Government of Canada has traditionally had some responsibility for the health of First Nations people living on reserves and in Inuit communities. The Government of Canada, primarily through the Medical Services Branch of Health Canada, provides three types of services to First Nations reserves and some Inuit communities:

1. Health stations with nurses working in expanded roles.
2. Health centres providing public health services.
3. Community Health Representatives (CHRs) are found in virtually all reserves and some Inuit communities. CHRs are trained to provide a combination of primary, public health and health promotion.

Aboriginal communities are taking on a greater role in managing and providing health care services. This transfer of responsibility has resulted from specific agreements between Aboriginal communities and the federal and provincial governments.

Despite the complexity of Aboriginal jurisdictional issues, it is clear that **provincial and territorial public health laws apply to people living on Indian Act Reserves and in Inuit communities.** Provincial and territorial public health laws also apply to Aboriginal people who live off reserve or away from traditional communities.

Public Health Laws — Province by Province by Territory

The tables that follow are a **summary of some of the important public health laws** in each province and territory. Public health laws can be complex and confusing. Often provincial and territorial laws and regulations have undergone many years of amendments. As a result, the language used is often outdated, the laws are piecemeal, and they do not clearly set out legal rights and responsibilities.

If you have specific questions about the application of public health laws you should consult a lawyer with expertise in public health law.

The table includes references to the acts and regulations that apply in each province, as well as the Web site addresses where the provincial or territorial laws and regulations can be viewed and downloaded. The information in the table is based on an analysis of the applicable public health laws and regulations.

The text used in the table is based on the relevant provincial and territorial laws, but is not the exact text used in the laws. In many cases the text has been summarized to make it easier to understand (believe it or not!).

The information in the **table is not comprehensive**. For example, a person ordered to do something (like get a medical examination, or go into quarantine) or to stop doing something (like having unprotected sexual intercourse, or sharing needles) under a law may have a right to appeal these types of orders. The appeal rights and procedures are not listed in the table. Also, it is often difficult to obtain provincial, territorial, local and regional policies. It was beyond the scope and resources of this project to research and analyze HIV/AIDS-related policies at the level of local and regional health authorities.

Finally, the **information in the table is current to 1 January 2004**.

[1] Institute of Medicine, USA, 1988.

[2] Culver, K., "Persons Unwilling or Unable to Prevent HIV Transmission: A Legislative Analysis and Literature Review," Federal/Provincial/Territorial Advisory Committee on AIDS, 2000; UNAIDS. Criminal Law, Public Health and HIV Transmission: A Policy Options Paper (Geneva, Switzerland, 2002).

Alberta

Law	Public Health Act, RSA 2000, Chapter P-37 Communicable Disease Regulation, Alberta Regulation 238/85, as amended. Available on the Alberta Queen's Printer Web site: www.qp.gov.ab.ca/custom_page.cfm?page_id=41
Policy	Alberta Treatment Guidelines: Sexually Transmitted Infections in Adolescents and Adults (Alberta Health and Wellness, 2003), available at: http://www.health.gov.ab.ca/professionals/STDTreatment.pdf
Reporting of HIV and AIDS	HIV and AIDS are "notifiable communicable diseases". (Regulation, Schedule 1) A physician, a health practitioner, a teacher, a person in charge of an institution and a director of a laboratory shall notify the medical officer of health of the regional health authority of known or suspected cases of HIV infection or AIDS within 48 hours using the prescribed form. (Act, section 22(1)) Individual occurrences of AIDS are reportable by all sources to the medical officer of health within 48 hours. (Regulation, Schedule 4, section 3)
Contact Tracing (partner counselling, partner notification)	Contact tracing measures apply to "recalcitrant patients". (Act, section 39(1)) A physician, community health nurse, midwife or nurse shall immediately notify the medical officer of health in the prescribed form where the practitioner knows or has reason to believe that a person: (a) is infected with a disease prescribed in the regulations for the purposes of this section, and refuses or neglects to submit to (i) a medical examination for the purpose of ascertaining whether the person is infected with that disease, or medical, surgical or (ii) other remedial treatment that has been prescribed by a physician and that is necessary to render the person non-infectious, or (iii) to comply with any other conditions that have been prescribed by a physician as being necessary to mitigate the disease or limit its spread to others. (Act, section 39(1)) Where the medical officer of health is satisfied as to the sufficiency of the evidence that the person may be infected, the medical officer of health shall issue a certificate in the prescribed form within 72 hours of the date of receiving of the notification from the medical practitioner. The certificate (Act, section 39(2)) "carrier" means a person who, without apparent symptoms of a communicable disease, harbours and may disseminate an infectious agent; (Act, section 1(c); Regulation, section 1(a.1)) "contact" means any person or animal suspected to have been in association with an infected person or animal or a contaminated environment to a sufficient degree to have had the opportunity to become infected (Act, section 1(h); Regulation, section 1(e)) The medical officer of health shall attempt to identify sexual contacts of the patient. (Regulation, Schedule 4, section 4) Information may be disclosed by the Chief Medical Officer of Health or regional health authority to any person where required by law, or to any person where there are reasonable grounds to believe that the disclosure will avert or minimize an imminent danger to the health or safety of any person, or to any person where the disclosure is necessary for the administration of the communicable diseases and public health emergencies section of the Act. (Act, section 53(4), (5))

Alberta (continued)

Identifying High Risk Behaviours	See "Contact Tracing".
Powers to Address High Risk Behaviours	See "Contact Tracing". No case of AIDS shall engage in any activity that may transmit the disease. (Regulation, Schedule 4, section 5) The medical officer of health can issue a certificate for a peace officer to apprehend the person, for a physician to conduct an examination, for a physician to treat or prescribe treatment, for a physician to prescribe any other conditions necessary to mitigate the disease or limit its spread to others. (Act, section 40(1)) A medical officer of health shall: (a) investigate all occurrences of notifiable diseases to establish the cause, the mode of transmission and the probable source and to identify others who may be at risk; (b) take whatever steps are reasonably possible (i) to suppress disease in those who may already have been infected with a communicable disease, (ii) to protect those who have not already been exposed, (iii) to break the chain of transmission and prevent spread of the disease, and (iv) to remove the source of infection. (Regulation, section 8) A medical officer of health may issue a certificate, isolation order or warrant for examination in the case of HIV or AIDS. (Regulation, Schedule 3)
Confidentiality	Information contained in any file, record, document or paper maintained by the Chief Medical Officer or by a regional health authority that indicates that a person is or was infected with a communicable disease shall be treated as private and confidential and shall not be used or disclosed in any manner that would be detrimental to the personal interest, reputation or privacy of that person. (Act, section 53(1)) Information may be disclosed by the Chief medical Officer of Health or regional health authority to any person where required by law, or to any person where there are reasonable grounds to believe that the disclosure will avert or minimize an imminent danger to the health or safety of any person, or to any person where the disclosure is necessary for the administration of the communicable diseases and public health emergencies section of the Act. (Act, section 53(4), (5))

British Columbia

Law	Health Act, RSBC 1996, Chapter 179 Health Act Communicable Disease Regulation, BC Regulation 4/83, as amended. Available on the British Columbia Queen's Printer Web site: www.qp.gov.bc.ca/statreg/default.htm
Policy	N/A
Reporting of HIV and AIDS	HIV and AIDS are "reportable communicable diseases" (Regulation, Schedule A) HIV is a "reportable communicable disease" (Regulation, Schedule B) "reportable communicable disease" means a disease listed in Schedule A or B, or which becomes epidemic or shows unusual features (Regulation, section 1) Where a person knows or suspects that another person is suffering from or has died from a communicable disease, he shall, without delay, make a report to the medical officer of health. (Regulation, section 2) Where a physician knows that a person is suffering from or has died from HIV or AIDS, he shall, without delay make a report to the medical officer. The report shall include the name of the disease; and the name, age, sex and address of the infected person. The physician must omit the name and address of the person if he or she voluntarily submitted to an HIV test and he or she chooses to have this information omitted. (Regulation, section 2(2), 4(1), 5)* * The HIV positive person's name and address may be reported to the medical health officer for the purposes of preventing harm, despite the fact that the person chose to have this information omitted from the report. See "Contact tracing". Where a person in charge of a laboratory knows or suspects as a result analysis, examination or tests that a person is suffering or has died from HIV, he shall, within 7 days, make a report to the medical health officer. The report shall include the name of the disease; the name, age, sex and address of the infected person; and the name and address of the physician or other person who has been providing care to the person tested. The lab director must omit the name and address of the person if he or she voluntarily submitted to an HIV test and he or she chooses to have this information omitted. (Regulation, section 2(3), 4(2), 5) The administrator or other person in charge of a hospital shall, within 7 days, make a report to the medical health officer respecting a patient admitted to the hospital who is suffering from HIV or AIDS. The report shall include the name of the disease; the name, age, sex and address of the infected person; and the name and address of the physician or other person who has been providing care to the person tested. The lab director must omit the name and address of the person if he or she voluntarily submitted to an HIV test and he or she chooses to have this information omitted. (Regulation, section 3, 4(3), 5) A householder (an occupant in charge of any premises, whether as owner, tenant or otherwise) who knows or suspects, or has reason to know or suspect, that any person in his or her family or household has HIV, must within 24 hours give notice to the medical health officer of the municipality or health district in which he or she resides. (Act, section 80)

British Columbia (continued)

Contact Tracing (partner counselling, partner notification)	"index patient" means a person known or suspected to be suffering from, or who has died from, a communicable disease. (Regulation, section 6.2(1)) "relevant information" includes any information that may, directly or indirectly, identify the index patient. (Regulation, section 6.2(1)) A physician who reasonably believes that another person may be at harm from an index patient may provide any relevant information to the medical health officer. (Regulation, section 6.2(2)(a)) On receiving that information, the medical health officer may request further relevant information from the physician, require the index person to undergo further examination and to provide relevant information, and disclose to any person who may be at risk of harm any relevant information the medical health officer feels necessary to address the harm or prevent further harm. (Regulation, section 6.2(2)(b))
Identifying High Risk Behaviours	Every medical practitioner and every person in charge of a place of detention must report all persons under their care suffering from a venereal disease by name, stating the venereal disease from which the person is suffering. (Venereal Disease Act, RSBC 1996, Chapter 475, section 2)
Powers to Address High Risk Behaviours	If a medical officer of health has reasonable grounds to believe that someone with HIV or AIDS is likely to wilfully, carelessly or because of mental incompetence, expose others to HIV, the medical health officer may order the person to do one or more of (a) comply with reasonable conditions the medical health officer considers desirable for preventing the exposure of other persons to HIV; (b) take or continue taking medical tests or treatment for the purposes of identifying or controlling HIV; (c) place him or herself in isolation, modified isolation or quarantine as set out in the order. (Act, section 11(1)) The person against whom the order is made, or anyone aggrieved by it, may within 10 days from the day that person is served with the order, file a written appeal to the Supreme Court of British Columbia. (Act, section 102) A medical health officer, deputy medical health officer, or assistance health officer can lay an information with the Provincial Court charging a person with contravening an order only with the prior approval of the Provincial health officer. The Supreme Court, on good cause shown, may vary or rescind the order. (Act, section 11) A Provincial Court can impose a monetary penalty or period of incarceration, confirm or vary the order of the medical health officer, prohibit the person from doing any act or engaging in any activity that may result in continued repetition of the offence, require the person to comply with any other condition or good conduct (Act, section 11(4), 104, 104.1).
Confidentiality	Where a person voluntarily submits himself to testing or examination for a communicable disease, and as a result another person is required to make a report to the medical health officer, no person shall disclose or permit to be disclosed to any person other than the medical health officer information contained in the report or the results of an examination or test, without the written consent of the person examined or tested. (Regulation, section 6(1)) * This confidentiality provision does not have to be followed for partner tracing. (Regulation 6.2(2))
Other	A person who considers himself or herself aggrieved or injured by the violation by any other person of any provision of the Act, or rules or regulations made under it, may lay an information and prosecute in respect of the violation. It is not necessary to a conviction the person prosecuting be actually aggrieved or injured. (Act, section 110)

Manitoba

Law	The Public Health Act, CCSM, Chapter P210 Diseases and Dead Bodies Regulation, Manitoba Regulation 338/88R, as amended. Available on the Manitoba Queen's Printer Web site: http://web2.gov.mb.ca/laws/statutes/index.php
Policy	Provincial Sexually Transmitted Disease Control Strategy (Communicable Disease Control Unit, Manitoba Health: August 2001), available at: http://www.gov.mb.ca/health/publichealth/cdc/std_strategy.pdf
Reporting of HIV and AIDS	HIV and AIDS are "sexually transmitted diseases". (Regulation, section 32) Diagnosis of HIV shall be made on the basis of a positive laboratory test for HIV. (Regulation, section 37(1)) Diagnosis of AIDS shall be made on the basis of a physical examination, medical history, positive laboratory test, the occurrence of an opportunistic infection, and any additional medical criteria the director considers appropriate. (Regulation, section 37(2)) A health professional who, while attending to a person, forms the opinion that the person has or may have a sexually transmitted disease, shall as soon as possible make a report to the director, and where that person has been in contact with another person in circumstances which it can reasonably be expected that the infected person has transmitted the disease to another person, or has been infected by another person, report the contact to the director. (Regulation, section 43(1)) The report shall be in a form approved by the minister and shall include full information, including details of the methods of examination. (Regulations, section 43(2)) The person in charge of a laboratory shall report all positive lab results for HIV within 48 hours. (Regulation, section 47) "communicable disease" means a disease designated as a communicable disease in the regulations (Act, section 1) "communicable disease", "contagious disease" or "infectious disease" means an illness due to a specific infectious agent or its toxic products which arises through transmission of that agent or its products from a reservoir to a susceptible host either directly from an infected person or animal, or indirectly through the agency of an intermediate plant or animal host, a vector, or the inanimate environment. (Regulation, section 2) The province's Chief Medical Officer of Health, or a person designated by the minister, may require any person to report information about diseases, and the person shall provide it. (Act, section 12.1(1), (3)).

Manitoba (continued)

Contact Tracing (partner counselling, partner notification)	"contact" means a person or animal who or which has been sufficiently near to an infected person or an animal or the environment contaminated by the animal or person, so as to have been exposed to transfer of infectious material either directly from the person or animal or indirectly from the environment. (Regulation, section 2) "carrier" means a person who harbours a specific infectious agent in the absence of discernable illness and serves as a potential source of infection to others. (Regulation, section 2) A health professional who, while attending to a person, forms the opinion that the person has or may have a sexually transmitted disease, shall as soon as possible make a report to the director, and where that person has been in contact with another person in circumstances which it can reasonably be expected that the infected person has transmitted the disease to another person, or has been infected by another person, report the contact to the director. (Regulation, section 43(1)) Where the Director believes that a person has or may have a sexually transmitted disease, or who has been in contact with a person who has a sexually transmitted disease in circumstances from which it can reasonably be expected that the person may have been exposed, the director may make an order that the person [no form exists setting out what orders may be made] (Regulation, section 48)
Identifying High Risk Behaviours	See "Contact Tracing".
Powers to Address High Risk Behaviours	HIV and AIDS are considered infectious until the director is satisfied that the danger of communication of the infection to other persons no longer exists. (Regulation, section 42) A medical officer of health can order any person whom he has reason to believe suffers from a communicable disease to submit to a medical examination, and authorize a public health nurse to examine any person suspected of having a communicable disease without the consent of the person. (Act, section 12(c), (k), 14) The Minister, Deputy Minister, Director of Public Health Services, Director of Preventative Medical Services, Director of Venereal Disease Control, or medical officer of health can order a person to be isolated, quarantined, to submit to or obtain a medical examination or treatment if he or she poses a threat to public health because he or she is suffering from a communicable disease, or has been in contact with a person exposed to a communicable disease. (Act, section 19(1)) Where a person fails or refuses to comply with an order or requirement, the person laying the order or requirement may apply to a justice of the peace to issue a warrant, under which a person shall be apprehended and submit to medical examination, obtain medical treatment, be isolated, quarantined or hospitalized, conduct himself or herself in such a manner as not to expose another person to infection. (Regulation, section 19)
Confidentiality	Except as authorized by law, no person engaged in the administration of the Regulation shall disclose any health information about an identifiable individual except to other persons engaged in the performance of public health, to the extent necessary to fulfil those duties. (Regulation, section 51)

New Brunswick

Law	Health Act, RSNB, Chapter H-2 General Regulation, NB Regulation 88/200, as amended. Public Health Act, SNB, Chapter P-22.4 **[NOT IN FORCE]** Available on the New Brunswick Department of Justice Web site: http://www.gnb.ca/0062/acts/acts-e.asp
Policy	N/A.
Reporting of HIV and AIDS	"acquired immune deficiency syndrome", "acquired immune deficiency syndrome related complex" and "HTLV-III virus antibody reactive status" are "communicable diseases" and "notifiable diseases". (Act, section 6(1)(o); Regulation, section 94(1)(s)) Where a medical practitioner, nurse, householder or other person recognizes or suspects the presence of a notifiable disease, a notification shall be sent to the district medical health officer or the nearest public health inspector who shall immediately notify the district medical health officer. The notification shall be made by a letter or card sent through the mail or by telegraph, telephone or direct personal communication and the information shall contain the name of the person infected or suspected to be infected, the place of residence and the name of the disease, if known. (Regulations, section 94(2), (3)) Where a notifiable disease occurs in any patient under medical care, the attending medical practitioner shall report, on a form provided by the Minister, the occurrence of the disease within twenty-four hours after its onset to the district medical health officer. (Regulation, section 97(2)) The Minister shall supply all medical practitioners in the Province with the forms on which to report any notifiable disease and with the instructions concerning the use of these forms. (Regulations, section 99)
Contact Tracing (partner counselling, partner notification)	N/A.
Identifying High Risk Behaviours	Upon receipt of the notification, the district medical health officer shall: (a) if necessary, cause the matter to be investigated and reported on; (b) enter in a book, kept for this purpose, the occurrence of each notifiable disease, together with the form provided for reporting the disease; (c) forward to the Director of Communicable Disease Control reports of notifiable diseases on the required form at stated intervals in accordance with the instructions on the form; (d) immediately report unusual or epidemic forms of disease to the Director of Communicable Disease Control by telephone or telegraph, together with all pertinent details concerning the outbreak. (Regulation, section 95)
Powers to Address High Risk Behaviours	A medical health officer may: (a) require any person whom he believes or has reason to believe is affected with a communicable disease to undergo medical examination; (b) isolate persons affected with communicable diseases. (Act, section 19(3)) The district medical health officer may take all measures, which have proven practical in public health administration and which have been accepted by public health authorities, to carry out any preventive measure considered necessary to control and prevent the diffusion of a notifiable disease. (Regulation, section 96)

New Brunswick (continued)

Confidentiality	The information, records of interviews, reports, statements, notes, memoranda or other data or material prepared by or supplied to or received by the officers of the Department in connection with research or studies relating to morbidity, mortality or the cause, prevention, treatment or incidence of disease, or prepared by, supplied to or received by any person engaged in such research or study with the approval of the Minister, shall be privileged and shall not be admissible in evidence in any court or before any other tribunal, board or agency except as and to the extent that the Minister directs. However, any information acquired by the Minister or any other person in relation to any matter under this Act shall be released as required under section 11.1 of the Family Services Act. (Act, section 33(1),(3)) Nothing prevents the publication of reports or statistical compilations relating to such research or studies which do not identify individual cases or sources of information or religious affiliations. (Act, section 33(2))

Newfoundland and Labrador

Law	Communicable Diseases Act, RSNL 1990, Chapter C-26. Newfoundland and Labrador Regulation 32/98 (Communicable Diseases Schedule), as amended. Available on the Newfoundland and Labrador House of Assembly Web site: http://www.gov.nf.ca/hoa/sr/body_main.htm
Policy	N/A.
Reporting of HIV and AIDS	HIV and AIDS are "communicable diseases". (Act, section 2(a), Schedule) "communicable disease" means a disease mentioned in the Schedule, and includes other diseases that may be added to the Schedule by the minister. (Act, section 2(a)). When a physician manager or recognized official head in charge of a hospital or residential institution, or a teacher or instructor of students in a school or college or other seminary of learning knows, or has reason to believe, that a person is infected with a communicable disease he or she shall within 24 hours give notice to the deputy minister, or to the health officer in whose jurisdiction the person is, and to the hotel-keeper, keeper of a boarding house or tenant within whose house or rooms the person lives. The notice to the deputy minister or to the health officer shall, where possible, state the name of the disease, the name, age and sex of the person, and the name of the physician giving the notice, and shall by street and number or otherwise, sufficiently designate the house or room in which the person is living. (Act, section 4, 5)
Contact Tracing (partner counselling, partner notification)	N/A.
Identifying High Risk Behaviours	Where a medical health office has reasonable grounds for believing that a person is or may be infected with or has been exposed to a communicable disease, the medical health officer may by written order direct that person to submit to an examination by the medical health officer or a physician designated by or satisfactory to the medical health officer and to obtain and produce or send to the medical health officer within the time specified in the notice a report or certificate of the physician that the person is or is not infected with the disease. Where, as the result of a report or certificate produced or sent to a medical health officer under subsection, it appears that a person is infected with a communicable disease, the medical health officer may … with the approval of the minister or the deputy minister order in writing that the person infected be, for the purpose of treatment, removed to and detained in a hospital for the treatment of the disease until the time that a physician attending at that hospital is satisfied that the infected person has received treatment and recovered sufficiently to be no longer a danger to the public and to be released from the hospital permanently or conditionally upon his or her returning for further examination or treatment or both. (Act, section 15)

Newfoundland and Labrador (continued)

Powers to Address High Risk Behaviours	See "Identifying High Risk Behaviours".
Confidentiality	N/A.

Nova Scotia

Law	Health Act, RSNS, Chapter 195 Communicable Disease Regulations, NS Regulation 28/57 Reporting Requirements for HIV Positive Persons Regulations, NS Regulation 31/2000 Available on the Nova Scotia House of Assembly Web site: http://www.gov.ns.ca/legi/legc/
Policy	Nova Scotia Communicable Disease Control Manual (Department of Health, 2003), Chapter 4 "Blood Borne Pathogens", available on the Nova Scotia Department of Health Web site: http://www.gov.ns.ca/health/publichealth/content/pubs/section_4_CDC_manual.pdf
Reporting of HIV and AIDS	HIV infection and AIDS are "notifiable diseases". (Communicable Diseases Regulation, section 11(1)) "notifiable disease" means a disease, the presence of which must, pursuant to this Act or the regulations, be made known to the director of a health unit, a medical health officer, a board of health or other officer. (Act, section 2(r); Communicable Disease Regulation, section 1(a)) When a householder or a physician or other person attending a person knows or has reason to believe that the person is infected with a notifiable disease other than venereal disease, the householder, physician or person shall within twenty-four hours give notice thereof to the medical health officer of the district where the person lives. A report shall be made in the first instance by telephone, if that is practical, and shall be followed by a written report. (Act, section 64) Where a person who requested nominal or non-nominal testing has tested positive, the physician shall report to the Health Unit Associate Director: (a) the name of the positive person (or the code where the person requested non-nominal testing); (b) the risk factors that may have caused HIV infection in the positive person; (c) the date or dates on which and the location or locations where the positive person may have received blood or other tissues; (d) the positive person's history of donations of blood or other tissues; (e) confirmation that partners have been notified; and (f) any other epidemiological information required in accordance with guidelines approved by the Chief Medical Officer. (HIV Reporting Regulation, section 7) Despite any other provisions of these regulations, a physician of a positive person shall report the name of the positive person and all relevant information obtained from the positive person to the Health Unit Associate Director where: (a) prior to testing positive, the positive person has made a donation of blood or other tissues; or (b) the Health Unit Associate Director, after consultation with the physician of the positive person, is of the opinion that the protection of the public health requires it. ((HIV Reporting Regulation, section 7(5)) Where a person has tested positive by anonymous testing, the counsellor shall report risk factor information regarding that positive person to the Health Unit Director in accordance with the guidelines approved by the Department. Where a person has tested negative by anonymous testing, the counsellor shall report risk factor information regarding that negative person to the Health Unit Director in accordance with the guidelines approved by the Department. (HIV Reporting Regulation, section 8(1)) The Minister shall, in the annual report of the Department, report on the effectiveness of the regulations respecting the reporting of persons who are HIV infected. (Act, section 12(5))

Nova Scotia (continued)

Contact Tracing (partner counselling, partner notification)	"partner" means an individual with whom a positive person has, since the probable earliest date of infection of the positive person, (i) engaged in unprotected anal, vaginal, or oral sexual intercourse, or (ii) shared injection drug use equipment, or (iii) engaged in some other behaviour which, in the opinion of a physician, carries a significant risk of infection with HIV (HIV Reporting Regulation, section 2(p)) "positive person" means (i) a person who has tested positive for HIV or any of its antibodies, or (ii) a person whom a physician has diagnosed as having AIDS. (HIV Reporting Regulation, section 2(r)) "risk factor" means an aspect of personal behaviour or lifestyle that is known to be associated with HIV infection. (HIV Reporting Regulation, section 2(t)) Before a physician or counsellor initiates an HIV test, the physician or counsellor shall counsel the person to be tested, in accordance with pre-test counselling guidelines approved by the Department. Where the person to be tested has had an occupational exposure to HIV, the physician or counsellor shall counsel the person in accordance with occupational exposure guidelines approved by the Department. (HIV Reporting Regulation, section 5) When a physician or counsellor communicates the result of an HIV test to a person, the physician or counsellor shall: (a) counsel the person in accordance with post-test counselling guidelines approved by the Department; and (b) if the person has tested positive, advise the person of the partner notification requirements. (HIV Reporting Regulation, section 6) As part of the counselling provided to the positive person, the physician or counsellor of a positive person shall advise the positive person about: (a) the positive person's responsibility to inform every partner of the positive person about their risk of exposure to HIV; (b) the partner notification guidelines approved by the Health Unit Director; and (c) the positive person's ability to transfer responsibility for partner notification to a physician or public health nurse who will notify partners on behalf of the positive person. (HIV Reporting Regulation, section 9) Where a person has tested positive, the positive person shall: (a) notify partners in accordance with partner notification guidelines approved by the Health Unit Director; or (b) transfer responsibility for partner notification to a physician or public health nurse who will notify partners on behalf of the positive person in accordance with partner notification guidelines approved by the Health Unit Director, in which case the positive person shall make all reasonable efforts to provide the names and other relevant information about every partner of the positive person to the physician or public health nurse. (HIV Reporting Regulation, section 10) If the physician of a positive person is not satisfied that a partner or a prospective partner of the positive person has been informed that he or she is at risk of infection with HIV, the physician of the positive person shall consult the Health Unit Associate Director. (HIV Reporting Regulation, section 11)
Identifying High Risk Behaviours	See "Contact Tracing".
Powers to Address High Risk Behaviours	N/A.

Nova Scotia (continued)

Confidentiality	The information, records of interviews, reports, statements, notes, memoranda or other data or material prepared by or supplied to or received by the officers of the Department in connection with research or studies relating to morbidity, mortality or the cause, prevention, treatment or incidence of disease, or prepared by, supplied to or received by any person engaged in such research or study with the approval of the Minister, shall be privileged and shall not be admissible in evidence in any court or before any other tribunal, board or agency except as and to the extent that the Minister directs. (Act, section 126)

Northwest Territories and Nunavut

Law	Public Health Act, RSNWT 1988, Chapter P-12. Disease Registries Act, RSNWT 1988, Chapter C-7 (Supp). Communicable Disease Regulations, RRNWT 1990, Chapter P-13. Reportable Diseases Order, RRNWT 1990, Chapter D-3. Available on the Canadian Legal Information Institute Web site: http://www.canlii.org/nt/sta/index.html
Policy	N/A.
Reporting of HIV and AIDS	HIV and AIDS are "communicable diseases". (Communicable Disease Regulation, section 1.1; Schedule A) HIV and AIDS are "reportable diseases". (Reportable Disease Act, section 1; Reportable Diseases Order, section 2) Every person who believes or has reason to believe or to suspect that another person is infected or has died from a communicable disease shall notify the Chief Medical Health Officer of this fact by the quickest means available and provide him or her with any further information that the Chief Medical Health Officer may require. (Communicable Disease Regulation, section 3) Where a medical practitioner or nurse has received a positive test result for one of his or her patients or a medical practitioner, nurse or dentist has reason to believe or suspect that one of his or her patients is infected with a communicable disease, the medical practitioner, nurse or dentist shall: (a) within seven days send a written report to the Chief Medical Health Officer in a form approved by the Chief Medical Health Officer; (b) advise the patient to adopt the specific control measures for the communicable disease in question; (c) provide the patient with the necessary information to comply with the control measures. (Communicable Disease Regulations, section 4(1)) A health care professional [medical practitioner, dentist, registered psychologist, nurse] who examines, diagnoses or treats a person in respect of a reportable disease shall provide the Registrar of Disease Registry with a report, including: (a) name, address, sex and age of the person; (b) a description of the reportable condition and the state of the reportable disease; (c) any other information the Registrar considers important. (Disease Registries Act, section 3)
Contact Tracing (partner counselling, partner notification)	"carrier" means a person who harbours and disseminates the specific micro-organisms of any communicable disease. (Communicable Disease Regulation, section 1) "contact" means a person or animal known to have been in association with a person or animal infected with a communicable disease and is presumed to have been exposed to infection from the infected person or animal. (Communicable Disease Regulation, section 1) "contact tracing" means: (a) identifying the contacts of a person who is or who, on reasonable grounds, is suspected of being infected with a communicable disease, (b) advising any contact identified to adopt the specific control measures for the communicable disease in question, and (c) providing the contact with the necessary information to comply with the measures. (Communicable Disease Regulation, section 1)

Northwest Territories and Nunavut (continued)

	Within seven days of giving notice of a positive test result, the medical practitioner or nurse shall, in accordance with guidelines provided by the Chief Medical Health Officer, carry out contact tracing or surveillance of those aspects of the occurrence and spread of the communicable diseases that are pertinent to the effective control of the disease, or request the Chief Medical Health Officer to carry out the contact tracing or surveillance. (Communicable Disease Regulation, section 4(1)(e))
Identifying High Risk Behaviours	N/A.
Powers to Address High Risk Behaviours	Where a person who is infected with a communicable disease refuses or neglects or is unable to comply with the instructions received from the Chief Medical Health Officer, the Chief Medical Health Officer, where satisfied that the conduct of that person is liable to endanger public health, may cause that person to be removed for isolation and any treatment that may be indicated, to a hospital or place of isolation (Communicable Disease Regulation, section 14(1))
Confidentiality	N/A.

Ontario

Law	Health Protection and Promotion Act, RSO 1990, Chapter H.7 Communicable Diseases — General Regulation, RRO 1990, 557, as amended. Specification of Communicable Diseases Regulation, Ontario Regulation 558/91, as amended. Specification of Reportable Diseases Regulation, Ontario Regulation 559/91, as amended. Reports Regulation, RRO 1990, 659, as amended. Available on the Government of Ontario E-Laws Web site: http://www.e-laws.gov.on.ca/home_E.asp?lang=en
Policy	Mandatory Health Programs and Services Guidelines (December 1997) available on the Ministry of Health and Long-Term Care Web site: http://www.health.gov.on.ca/english/providers/pub/pubhealth/manprog/manprog.html Sexually Transmitted Diseases (STDs): STD Control Protocol (Mandatory Health Programs and Service Guidelines, Public Health Branch, December 1997).
Reporting of HIV and AIDS	AIDS is a "communicable disease" and a "reportable disease". (Specification of Communicable Diseases Regulation, section 1; Specification of Reportable Diseases Regulation, section 1). Where a physician or a practitioner [chiropractor, dentist, nurse, pharmacist, optometrist, drugless practitioner] while providing professional services to a person who is not a patient in or an out-patient of a hospital, forms the opinion that the person has or may have a **reportable disease** shall, as soon as possible after forming the opinion, report thereon to the medical officer of health of the health unit in which the professional services are provided. (Act, section 25(1), (2)) A physician who forms the opinion that the person is or may be infected with an **agent of a communicable disease** shall, as soon as possible after forming the opinion, report thereon to the medical officer of health of the health unit. (Act, section 26) The administrator of a hospital, or superintendent of an institution, shall report as soon as possible to the medical officer of health of the health unit in which the hospital, or institution, is located if an entry in the records of the hospital in respect of a patient in or an out-patient of the hospital states that the patient or out-patient has or may have a **reportable disease** or is or may be infected with an agent (Act, section 27) A report by a physician or a practitioner [chiropractor, dentist, nurse, pharmacist, optometrist, drugless practitioner] administrator of a hospital, or superintendent of an institution of the Act shall, with respect to the person to whom the report relates, contain: (a) Name and address in full; (b) Date of birth in full; (c) Sex; (d) Date of onset of symptoms; and (e) additional information respecting the reportable disease or communicable disease, as the case may be, as the medical officer of health considers necessary. (Reports Regulation, section 1)

Ontario (continued)

A report of **AIDS by a physician** shall also include: (a) The date of diagnosis; (b) The name and telephone number of the physician attending the person; (c) The name of the hospital if the person is admitted to a hospital or is an outpatient; (d) Medical conditions of the person including laboratory findings and date of onset of symptoms that are indicative of Acquired Immune Deficiency Syndrome; (e) Other medical conditions of the person that may have caused immuno-suppression (exclusion criteria); (f) Country of birth, date of arrival in Canada, race and residence of the person at onset of illness; (g) Current status of person infected (alive or dead) (if dead give date of death); (h) Information preceding the diagnosis of Acquired Immune Deficiency Syndrome with respect to (i) sexual relations of the person with a male partner, (ii) sexual relations of the person with a female partner, (iii) use by the person of needles for self-injection of drugs not prescribed by a physician, or (iv) receipt by the person of blood or blood products (give dates); (i) Information, preceding the diagnosis of Acquired Immune Deficiency Syndrome, with respect to heterosexual relations of the person with another person who is, (i) an intravenous abuser, (ii) a bisexual man, (iii) a person with hemophilia or a coagulation disorder, (iv) a blood transfusion recipient with Acquired Immune Deficiency Syndrome or documented Human Immune Virus infection, (v) a person with Acquired Immune Deficiency Syndrome or documented Human Immune Virus infection, (vi) a person who was born or resided in a country where heterosexual transmission of Acquired Immune Deficiency Syndrome predominates (specify country); (j) Information preceding the diagnosis of Acquired Immune Deficiency Syndrome, as to whether the person has worked or is working in a health care or clinical laboratory setting (give occupation and setting); (k) Information, preceding the diagnosis of Acquired Immune Deficiency Syndrome, as to whether there are no identifiable risk factors or any other exposures that could have been the source of the infection; (l) Information, in the case of a child who is one year of age or older but less than sixteen years of age, as to whether the child was infected as a result of perinatal transmission. (Reports Regulation, section 5-3)

A principal of a school, who forms the opinion that the person is or may be infected with an **agent of a communicable disease** shall, as soon as possible after forming the opinion, report thereon to the medical officer of health of the health unit. (Act, section 28)

A report by a school principal shall, with respect to the pupil to whom the report relates, contain the following information: (a) Name and address in full; (b) Date of birth in full; (c) Sex; (d) Name and address in full of the school that the pupil attends. (Reports Regulation, section 2)

The operator of a laboratory shall report to the medical officer of health of the health unit in which the laboratory is located each case of a positive laboratory finding in respect of a **reportable disease**, as soon as possible after the making of the finding. (Act, section 29 (1))

A report by the operator of a laboratory shall, with respect to the person to whom the finding was made, be made within twenty-four hours of the making of the finding and shall contain the following information: (a) Name and address in full; (b) Date of birth in full; (c) Sex; (d) Date when the specimen was taken that yielded the positive finding; and (e) Name and address in full of the physician or dentist attending the person. (Reports Regulation, section 3)

A **physician** and **operator of a laboratory** who provides **anonymous HIV testing** to a patient in a specified clinic is exempt from reporting the patient's name and address if, before the test was ordered, the patient received counselling about preventing the transmission of HIV infection. (Reports Regulation, section 5.1(2),(3))

Ontario (continued)

	Every medical officer of health shall report to the Ministry in respect of **reportable diseases** and in respect of deaths from such diseases that occur in the health unit served by the medical officer of health. (Act, section 31(1)) Where an order by a medical officer of health in respect of a **communicable disease** is directed to a person under sixteen years of age and is served upon the parent of the person or upon any other person who has the responsibilities of a parent in relation to the person under sixteen years of age. (Act, section 23)
Contact Tracing (partner counselling, partner notification)	The Minister may publish guidelines for the provision of mandatory health programs and services and every board of health shall comply with the published guidelines. (Act, section 7(1)) Every board of health shall superintend, provide or ensure the provision of health programs and services in (1) control of infectious diseases and reportable diseases, including provision of immunization services to children and adults; (2) health promotion, health protection and disease and injury prevention, including the prevention and control of cardiovascular disease, cancer, AIDS and other diseases; (3) family health, including counselling services. (Act, section 5) A board of health shall provide infectious disease policy and procedure manual. (Mandatory Health Programs and Services Guidelines, Control of Infectious Diseases, 1e) A board of health shall ensure public health management of persons found to be infected with an agent of a communicable disease in accordance with the infectious disease policy and procedure manual of the board of health. (Mandatory Health Programs and Services Guidelines, Control of Infectious Diseases, 3c) A board of health shall ensure the identification and appropriate management of contacts of persons found to be infected with an agent of a communicable disease in accordance with the infectious disease policy and procedure manual of the board of health. (Mandatory Health Programs and Services Guidelines, Control of Infectious Diseases, 3d) The board of health shall, at a minimum, follow the STD Control Protocol (December, 1997), including STD patient management, identification of contacts, partner notification and referral. (Mandatory Health Programs and Services Guidelines, Sexually Transmitted Diseases (STDs) Including HIV/AIDS, 2a,b,c) See detailed contact tracing and partner notification standards and procedures in Chapter 7, Sexually Transmitted Diseases (STDs): STD Control Protocol setting out types of contact identification and notification, time frame for identification, case interview, contact interview, follow-up.
Identifying High Risk Behaviours	See "Contact Tracing".

Ontario (continued)

Powers to Address High Risk Behaviours	A medical officer of health by a written order may require a person to take or to refrain from taking any action, including requiring the person to: (a) submit to an examination by a physician and to deliver to the medical officer of health a report by the physician as to whether or not the person has a communicable disease or is or is not infected with an agent of a communicable disease; (b) conduct himself or herself in such a manner as not to expose another person to infection. (Act, section 22 (1), (3)) To make an order, the medical officer of health must be of the opinion, upon reasonable and probable grounds that: (a) a communicable disease exists or may exist; (b) the communicable disease presents a risk to the health of persons in the health unit served by the medical officer of health; and (c) the order is necessary in order to decrease or eliminate the risk to health presented by the communicable disease. (Act, section 22(2))
Confidentiality	Before disclosing personal information, a medical officer of health shall delete from it all names and identifying numbers, symbols or other particulars assigned to individuals unless: (a) disclosure of the names or other identifying information is necessary for the purposes necessary to the Act; or (b) disclosure of the names or other identifying information is otherwise authorized under the Freedom of Information and Protection of Privacy Act or the Municipal Freedom of Information and Protection of Privacy Act. (Act, section 91.1(5))

Prince Edward Island

Law	Public Health Act, RSPEI 1988, Chapter P-30 Available on the Prince Edward Island Legislative Counsel Office Web site: http://www.gov.pe.ca/infopei/Law_and_Justice/Statutes/ Notifiable and Communicable Diseases Regulation, RRPEI, Chapter P-30.
Policy	N/A.
Reporting of HIV and AIDS	HIV antibodies and AIDS are "notifiable diseases". (Regulations, section 17(a)) "communicable disease" means an illness caused by an infectious agent or its toxic products which is transmitted directly or indirectly to a person from an infected person or animal or through the agency of an intermediate environment and includes any disease prescribed as a communicable disease by the regulations. (Act, section 1(b)) "regulated" means any communicable disease of condition which in the opinion of the Chief Health Officer, owing to its properties of contagion, the seriousness of its effects, and unusual effects or some such other factor poses a significant risk to public health, and may include notifiable diseases. (Regulation, section 1(h)) Any occurrence of HIV antibodies or AIDS must be reported to the Chief Health Officer or his designate. (Regulations, section 17(a)) A physician shall report any occurrence of a notifiable or other regulated disease to the Chief Health Officer: (a) in such manner as may be requested by the Chief Health Officer; (b) including such further information regarding the patient who is or suspected of being infected with a regulated, disease, including the patient's condition, contacts and compliance with treatment and control measures; (c) carry out treatment and control measures as directed by the Chief Health Officer. (Regulation, section 6)
Contact Tracing (partner counselling, partner notification)	"carrier" means a person who, without apparent symptoms of a disease, harbours and may disseminate the infectious agent. (Regulation, section 1(a)) "contact" means a person who has been exposed to or been in such association with and infectious agent as to have the opportunity of acquiring the infection. (Regulation, section 1(b)) A person who is, or is suspected of being, infected with a regulated disease, including a suspected carrier or contact, shall: (a) place himself under the care of a physician or direction of a health officer; (b) submit to such diagnostic examination, treatment and control measures as may be directed by the physician, Chief Health Officer or delegate; (c) identify any contact, and provide such other relevant information as may be required. (Regulation, section 4)
Identifying High Risk Behaviours	A person who is, or is suspected of being, infected with a regulated disease, including a suspected carrier or contact, shall: (a) place himself under the care of a physician or direction of a health officer; (b) submit to such diagnostic examination, treatment and control measures as may be directed by the physician, Chief Health Officer or delegate; (c) identify any contact, and provide such other relevant information as may be required. (Regulation, section 4)

Prince Edward Island (continued)

Powers to Address High Risk Behaviours	Any public health officer, or nursing health officer, if he has reasonable and probable grounds to believe that there exists therein a hazard to public health may cause such steps to be taken as he considers necessary to alleviate any hazard to public health, including entering any building without the consent of the owner or occupant thereof and, for the purpose of investigating any reasonably suspected case of communicable disease or public health hazard, examine any person, conduct any necessary tests and take any necessary samples without consent or refer him for this purpose to a physician who may act under the authority of the Chief Health Officer. (Act, section 15, 16) A physician shall report any occurrence of a notifiable or other regulated disease to the Chief Health Officer and shall carry out treatment and control measures as directed by the Chief Health Officer. (Regulation, section 6) Any direction for examination, treatment or control measures respecting a person under the age of sixteen years shall be given to the parent or guardian. (Regulation, section 13(2)) A physician, the Chief Health Officer or his delegate may give information concerning the condition of a person who is or suspected of being infected with a notifiable of other regulated disease to members of the person's family for the protection of their health. (Regulation, section 14)
Confidentiality	Each person employed in the administration of this Act shall preserve secrecy with respect to all matters that come to his knowledge in the course of his employment and which pertain to health services rendered in that regard, and shall not communicate any matters to any other person except as provided in this section. However, nothing prevents the divulging of information: (a) with the consent of the person to whom the information relates, or (b) to the extent that the Chief Health Officer directs in the best interest of that person or the public. Nothing prevents the disclosure of any information obtained pursuant to the provisions of this Act where (a) in the opinion of the Minister, it is in the public interest to release the information; and (b) information relating to a person's health or health care is not disclosed. (Act, section 22)

Quebec

Law	Public Health Act, RSQ, Chapter S-2.2 Minister's Regulation under the Public Health Act, Gazette Officielle du Québec, 5 November 2003, No 45, page 3290 Available on the Publications Québec Web site: http://publicationsduquebec.gouv.qc.ca/home.php
Policy	For more information on illness and infections that must be reported, and reporting guidelines and forms, see the Québec Ministry of Health and Social Service Web site (in French only): http://www.msss.gouv.qc.ca/sujets/santepub/mado.html
Reporting of HIV and AIDS	Any physician who diagnoses HIV infection or AIDS in a person who has received blood, blood products, organs or tissues must report the diagnosis to the health director in the territory, by means of written report within 48 hours. The report must provide: (a) the name of the infection or disease; (b) name, sex, occupation, date of birth, address with postal code, telephone number and health insurance number of the person affected; (c) where samples have been taken for laboratory analysis, the date on which the samples were taken and the name of the laboratory that will analyse them; (d) the physician's name and professional permit number and telephone number. (Regulation, section 4, 6) **HIV** The Laboratoire de santé publique du Québec must transmit any confirmed positive laboratory analysis for HIV to the person designated by the national public health director, and provide the following information for ongoing surveillance of the health status of the population: (a) the name and permit number of the health professional who requested the analysis; (b) if it is available, the patient's health insurance number. (Regulation, section 10) Where the health insurance number has not been provided, the Laboratoire de santé publique must contact the health professional who requested the HIV test to obtain the health insurance number of the person. (Regulations, section 11) To ensure the confidentiality of the information, the Laboratoire de santé publique must verify whether a similar HIV test result has already been transmitted for the same person. To do so, the person's health insurance number is encrypted. If the number is already encrypted, no additional steps are taken. (Regulations, section 11) Where the health insurance number has not been encrypted, the Laboratoire de santé publique must contact the health professional who requested the HIV test to obtain information regarding the person for ongoing surveillance of the health status of the population: (a) month and year of birth; (b) sex; (c) place of residence and first three characters of the postal code; (d) ethno-cultural origin, country of birth and, where applicable, date of arrival in Canada; (e) risk factors associated with the virus; (f) history of previous tests, clinical status and other relevant laboratory data; (g) reason for the test; (h) in the case of a woman, whether she is pregnant. (Regulation, section 12)

Quebec (continued)

	AIDS Any physician who diagnoses a person with AIDS must send the following information to the Laboratoire de santé publique for ongoing surveillance of the health status of the population: (a) date of birth; (b) sex; (c) place of residence and first three characters of the postal code; (d) vital status; (e) ethno-cultural origin, country of birth and, where applicable, date of arrival in Canada; (f) indicators of AIDS that have been diagnosed and dates of diagnosis; (g) results of HIV tests, including confirmatory tests, with corresponding dates; (h) other relevant laboratory data; (i) the number the physician has assigned to the patient as a reference number; (j) the physician's permit number; (k) the physician's telephone numbers; (l) the date the information was sent. (Regulation, section 14)
Contact Tracing (partner counselling, partner notification)	N/A.
Identifying High Risk Behaviours	N/A.
Powers to Address High Risk Behaviours	N/A.
Confidentiality	Encryption of information obtained from health profession. (Regulation, section 11, 12) See "Reporting", above. Once the personal information required to be reported for an HIV-positive test has been obtained, it must be recorded in a file in such a way as to ensure that the information cannot be associated with the person's health insurance number. (Regulation, section 13) The physician assigned a reference number to his or her patient when reporting a diagnosis of AIDS. (Regulation, section 14) The regional council and the regional boards shall ensure that all personal and confidential information obtained by public health directors in the exercise of their functions is kept by the public health department in such manner as to preserve its confidentiality and that the persons having access to the information in the exercise of their functions undertake under oath not to disclose or communicate the information without being duly authorized to do so. Such confidentiality undertaking shall be periodically renewed. (Public Health Act, section 131) A public health director and the persons exercising their functions for the public health department may not communicate personal and confidential information except pursuant to an order of the Court or of a coroner in the exercise of a coroner's functions, or with the consent of the persons to whom the information relates. They may, however, communicate any information necessary for the administration of the Public Health Act, and in the event of a threat to the health of the population. (Public Health Act, section 131, 132)

Saskatchewan

Law	The Public Health Act, 1994, SS 1994, Chapter P-37.1 Disease Control Regulations, SReg Chapter P-37.1, r 11 Available on the Saskatchewan Queen's Printer Web site: http://www.qp.gov.sk.ca/
Policy	N/A.
Reporting of HIV and AIDS	AIDS and HIV infection are "category II communicable diseases". (Act, section 2(f); Regulation Table 2) In the case of human immunodeficiency virus infection and acquired immune deficiency syndrome, a physician or a clinic nurse must report the following information unless the person has taken an anonymous HIV-antibody test and does not agree to having the information collected: (a) the name of the disease; (b) the name and telephone number of the infected person's physician or clinic nurse; (c) the initials of the first, middle and last names of the infected person; (d) the gender and date of birth of the infected person; (e) the mailing address and place of residence of the infected person; (f) the ethnocultural background of the infected person; (g) the names of other diseases that the infected person has or has had that are diseases indicative of acquired immune deficiency syndrome; (h) the risk factors known to be associated with the transmission of the infection to the infected person. (Regulation, section 14(3), 15) Where a person tested at an anonymous test site does not agree to the collection of personal information, the operator of the anonymous test site shall report the following information in the format approved by the department: (a) the gender of the infected person; (b) the year of birth of the infected person; (c) the risk factors known to be associated with the transmission of the infection of the infected person. (Regulation, section 15) If requested to do so by a designated public health officer, a physician or clinic nurse shall disclose orally to the designated public health officer the name of a person infected with human immunodeficiency virus unless the person was diagnosed at an anonymous test site. (Regulation, section 16) Where the existence of a category II communicable disease is found or confirmed by examination of specimens submitted to a medical laboratory … the manager of the medical laboratory shall, within 48 hours after confirmation of the results, send a copy of the laboratory report that identifies the disease to a medical health officer. The report must contain the information prescribed in the regulation. (Act, section 36) Where a designated public health officer becomes aware that a person infected with any communicable disease that is transmissible through blood or a blood product … has donated blood or a blood product within a period in which that infection could have been transmitted, or has received blood or a blood product within a period in which that infection could have been acquired, the designated public health officer shall notify the medical head of the Canadian Blood Services in Saskatchewan of the following: (a) the name and date of birth of the infected person; (b) the name of the disease; (c) the date of donation or receipt of the blood or blood product; (d) the location of the facility where the blood or blood product was donated or received; and (e) if the designated public health officer becomes aware of the infection by means of a laboratory report, the information set out in the laboratory report. (2) A person may disclose the name of an infected person mentioned in clause (1)(a) only: (a) in the circumstances set out in subsection 65(2) of the Act; or (b) to an employee of a medical laboratory who requires the information for the purposes of determining whether a person infected with a disease mentioned in subsection (1) has donated or received blood or a blood product.

Saskatchewan (continued)

	The manager of a laboratory owned and operated by the Canadian Blood Services shall send a copy of a laboratory report to a designated public health officer within seven days after confirmation of the results of an examination of specimens for HIV. The report must contain the following information: (a) a unique identifier, the gender and date of birth of the infected person; (b) the name and address of the physician; (c) the date on which the specimen was taken; (d) the test results. (Regulation, section 17) Where a designated public health officer becomes aware that a worker, as defined in The Occupational Health and Safety Act, 1993, has contracted a category I or category II communicable disease as a result of an occupational exposure, the designated public health officer, within 14 days after becoming aware that the worker has contracted the disease, shall notify the director, as defined in that Act, of the following: (a) the name of the disease; (b) the name and address of the place of employment where the disease is believed to have been contracted. (Regulation, section 9) At prescribed intervals, a medical health officer shall submit to the co-ordinator of communicable disease control a report of all cases of category I and category II communicable diseases reported to the medical health officer. (Act, section 37)
Contact Tracing (partner counselling, partner notification)	Contact tracing does not apply to a person who utilizes the services of an anonymous test site and is diagnosed as being infected with human immunodeficiency virus. (Act, section 33(4); Regulation, section 11(4)) A person who is diagnosed as being infected with human immunodeficiency virus and who communicates with his or her contacts shall do so as soon as possible within 30 days after the diagnosis. He or she shall: (a) answer all questions asked by the physician or clinic nurse; (b) provide the names, addresses, telephone numbers, age and sex of all of his or her contacts to the physician or clinic nurse; and (c) on being diagnosed: (i) communicate in the prescribed manner with all of his or her contacts; or (ii) ask the physician or clinic nurse to communicate in the prescribed manner with the person's contacts. (Act, section 33; Regulation, section 11(4)) Where the person contacts his or her partners, he or she shall: (a) inform each contact of his or her exposure to the disease in question; and (b) explain to each contact the contact's duty: (i) to protect himself or herself by going to a physician or clinic nurse for testing and care; and (ii) to take all reasonable measures to reduce significantly the risk of infecting others. (Regulation 6(2)) If it is not practicable for a person to communicate with the contacts within the person shall ask the physician or clinic nurse to communicate with the contacts. The physician or clinical nurse shall, within 14 days after receiving the request: (a) inform each contact of his or her exposure to the disease in question; (b) explain to each contact the contact's duty: (i) to protect himself or herself by going to a physician or clinic nurse for testing and care; and (ii) to take all reasonable measures to reduce significantly the risk of infecting others; and (c) provide counselling. (Act, section 34(2); Regulations, section 7, 6(3))

Saskatchewan (continued)

	If the physician or clinical nurse cannot complete the communication with the contacts within 14 days, or the physician or clinical nurse forms the opinion that the person who is infected has not communicated, and does not intend to communicate, with his or her contacts and has not asked the physician or clinical nurse to do so, the physician or clinical nurse shall immediately refer the list of contacts to a designated public health officer. The designated public health officer shall: (a) inform each contact of his or her exposure to the disease in question; (b) explain to each contact the contact's duty: (i) to protect himself or herself by going to a physician or clinical nurse for testing and care; and (ii) to take all reasonable measures to reduce significantly the risk of infecting others; and provide counselling. (Act, section 34(3), 35; Regulations, section 7, 8)
Identifying High Risk Behaviours	A person who becomes aware or suspects that he or she is infected with human immunodeficiency virus or has been exposed to that virus shall consult a physician or clinic nurse with respect to that infection or exposure as soon as possible within 30 days after becoming aware of or suspecting that infection or exposure. From the time that a person becomes aware or suspects that he or she is infected with human immunodeficiency virus or has been exposed to that virus, the person shall immediately take all reasonable measures to reduce significantly the risk of infecting others, in addition to considering any advice provided by a physician or clinic nurse. (Act, section 33; Regulation, section 11(1), (2)) As soon as is practicable, and in any case not later than 72 hours after forming an opinion that a person is infected with or is a carrier of a category II communicable disease, a physician or clinic nurse shall: (a) provide counselling to the person concerning: (i) measures that the person may take to reduce the risk of complications from the disease and the spread of the disease to others; (ii) measures that the physician or clinic nurse considers necessary for effective treatment or management of the disease; and (iii) any other matter that the physician or clinic nurse considers necessary; (b) ask the person to provide any information that the physician or clinic nurse considers necessary to control the spread of the disease, including the names, addresses, telephone numbers, age and sex of all of the person's contacts; (c) begin therapy; and (d) report the prescribed information to a medical health officer in the prescribed manner. (Act, section 34(1))

Saskatchewan (continued)

Powers to Address High Risk Behaviours	A medical health officer may order a person to take or refrain from taking any action specified in the order that the medical health officer considers necessary to decrease or eliminate a risk to health presented by a communicable disease, including: (a) require a person who is or probably is infected with, or who has been or might have been exposed to, a communicable disease to isolate himself or herself immediately and to remain in isolation from other persons; (b) require a person who is or who is probably infected to submit to an assessment of the person's condition by: (i) being tested and examined by a physician or a clinic nurse; and (ii) permitting the taking of specimens of body tissues, blood and other fluids for laboratory examination; (c) require a person to present himself or herself for counselling with respect to measures to treat the disease effectively, to reduce risk behaviours and to reduce the spread of the disease; (d) require a person to conduct himself or herself in a manner that will not expose another person to infection; (h) require a person infected with a communicable disease to receive uninterrupted treatment or counselling until, in the opinion of the medical health officer, the person no longer poses a public health risk; (i) require an infected person to place himself or herself under the care and treatment of a physician and, where admitted to a hospital by that physician, to remain there until the medical health officer certifies that the person: (i) is no longer infected so as to endanger the health of others; or (ii) is no longer able to benefit from treatment; (e) require an infected person to desist from any occupation or activity that may spread the disease; (f) require a person with knowledge of the names of members of a group to disclose to a medical health officer the names of individual members of that group who are suspected by a medical health officer of: (i) having been in contact with a person infected with a communicable disease; or (ii) having been infected with a communicable disease; (g) require a person who is the subject of an order pursuant to this section to do anything that is reasonably necessary to give effect to that order. (Act, section 38) As a general rule: (a) an order must be in writing; (b) may specify time limits for commencing any action required by the order and for complying with the order or any portion of the order; (c) may specify the manner, method or procedures to be used in complying with the order; (d) may be revoked, suspended or amended by the person who made the order or by another person acting in the same capacity. (Act, section 57)
Confidentiality	As a general rule, no person shall disclose any information that comes to the person's knowledge in the course of carrying out responsibilities under the Public Health Act, 1994 or regulations, concerning a person who: (a) is infected with or is suspected to be infected with a communicable disease; (b) is a carrier of or is suspected to be a carrier of a communicable disease; (c) is a contact of a person mentioned in clause (a) or (b); or (d) has or has had a non-communicable disease or an injury. (Act, section 65(1)) Exceptionally, a person may disclose that information where the disclosure: (a) is required: (i) to administer this Act, the regulations or bylaws made pursuant to this Act; (ii) to carry out a responsibility imposed or to exercise a power conferred by this Act, the regulations or bylaws made pursuant to this Act; or (iii) by law; (b) is requested or approved by the person who is the subject of the information; (c) is ordered by the minister for the purpose of protecting the public health; or (d) is made: (i) to a physician or nurse or in the course of consultation; (ii) to a person who is conducting bona fide research or medical review if the disclosure is made in a manner that ensures the anonymity of the information; (iii) between solicitor and client; (iv) in the case of information pertaining to a child under 14 years of age, to a parent of the child or to a person who stands in loco parentis to the child; or (v) in circumstances prescribed in the regulations. (Act, section 65)

Yukon

Law	Public Health and Safety Act, RSY 2002, Chapter 176 Communicable Disease Regulations, CO 1964, 048, as amended. Available on the Canadian Legal Information Institute Web site: http://www.canlii.org/yk/sta/index.html
Policy	Indicate if no legislation applies.
Reporting of HIV and AIDS	HIV infection and AIDS are "communicable diseases" (Act, section 1; Regulation 2(a), Schedule B) Every medical practitioner who has reason to believe or suspect that one of his patients is infected with a communicable disease shall notify a Medical Health Officer immediately of the action taken and shall give him any further information that such officer may require. (Regulations, Section 5(3)) Every Medical Health Officer shall: (a) keep a register of all cases of communicable diseases of which he is notified, and (b) forward to the Chief Medical Health Officer on the last day of each week a report of all cases of communicable diseases of which he received notice during the week, together with any further information that such officer may require; except that where … there is an unusual outbreak or extension or multiplication of a communicable disease, the Medical Health Officer shall report immediately by the quickest means available and thereafter report as often as is necessary to keep the Chief Medical Health Officer informed of the spread of the disease. (Regulations, section 10)
Contact Tracing (partner counselling, partner notification)	"contact" means a person or animal known to have been in association with a person or animal infected with a communicable disease and is presumed to have been exposed to infection therefrom. (Regulations, section 2(e)) "carrier" means a person who harbours and disseminates the specific micro-organisms of any communicable disease. (Regulations, section 2(b)) Every medical practitioner who has reason to believe or suspect that one of his patients is infected with a communicable disease shall advise such patient, any persons attending him and any known contacts or carriers, to adopt the specific control measures for such disease and shall give them the necessary instructions therefore. (Regulations, section 5(1))
Identifying High Risk Behaviours	Every person who believes or has reason to believe that he is infected with a communicable disease shall: (a) notify as soon as possible the nearest medical practitioner or Medical Health Officer by the quickest means available, and (b) place himself under the care of, undergo the treatment and follow the course of action prescribed therefore by the medical practitioner or Medical Health Officer. (Regulations, section 3)
Powers to Address High Risk Behaviours	A Medical Health Officer may: (a) enter in the daytime any dwelling, premises, vehicle or conveyance, to inquire as to the state of health of any person therein; (b) examine physically or by questioning any such person whom he suspects of being infected with a communicable disease; (c) direct such person (i) to submit to the taking of specimens of his blood and of any other body fluids, (ii) to give specimens of his sputum and other excreta, (iii) to submit to X-ray, and (iv) to undergo any procedure that may be required in the discretion of the Medical Health Officer to prevent the spread of a communicable disease. (Regulations, section 12)

Yukon (continued)

	A Medical Health Officer may give any direction that he deems necessary to enforce these regulations. (Regulations, section 17) A health officer has for any purpose relating to the enforcement of this Act or the regulations, all the powers of a peace officer while acting in their capacity as a health officer and in the performance of their duties under this Act or the regulations, and if any health officer is obstructed in the performance of any duty they may call to their assistance any peace officer or other person they think fit, who shall give the health officer all reasonable assistance. (Act, section 14, 15)
Confidentiality	N/A.

Disclosure of HIV Status After *Cuerrier*

6

Counselling and HIV Disclosure: Standards and Approaches

- This section of the Resource Guide can be used to:
- Familiarize counsellors with suggested minimum legal and ethical standards for counselling clients regarding HIV disclosure.
- Familiarize counsellors with suggested approaches to counselling clients about HIV disclosure issues.
- Develop organizational policies and guidelines on counselling PHAs about HIV disclosure.

Who is a Counsellor?

This chapter is meant for **everyone working in a community based organization who counsels PHAs**. It is not just for a person who has the job title of "counsellor", who has a degree in counselling, or who is registered with a professional regulatory body (like registered nurses and registered social workers). It is designed to give guidance to professionals and non-professionals, people who have formal training in counselling and those who learned counselling on the job.

The information in this chapter can also serve as **a resource for people who counsel PHAs in clinics, hospitals, HIV-testing sites, and individual nurses, public health nurses and physicians**.

Counselling sometimes takes place during a scheduled appointment, in an office, across a desk, where the counsellor takes written notes. But we know that counselling also take place in much less formal settings — after meetings, at drop-ins, in bars, bathhouses, parks, alleys, and street-based needle exchanges to list a few. The information in this chapter has been put together with this reality in mind.

The information in this section is intended to inform and guide the process of counselling PHAs about HIV disclosure issues. The information is intended to help organizations respond to the challenges of HIV disclosure in ways that **protect the rights and dignity of PHAs, achieve the public health goal of reducing HIV transmission, and lessen the impact of HIV on affected individuals and communities through empowerment.**

Counselling Goals — Encouraging Beneficial Disclosure

The goals of counselling in the context of disclosure of HIV-positive status include:

- To provide clients with **information about their legal rights and the potential legal consequences of non-disclosure**.

> UNAIDS and the World Health Organization encourage **beneficial disclosure**. This is disclosure that is voluntary; respects the autonomy and dignity of the affected individuals; maintains confidentiality as appropriate; leads to beneficial results for those individuals; *and* for their families and sexual and drug-injecting partners; leads to greater openness in the community about HIV/AIDS; and meets the ethical imperatives of the situation where there is need to prevent onward transmission of HIV. — UNAIDS, *Opening up the HIV/AIDS Epidemic* (2000)

- To help clients **integrate awareness of their HIV infection** as a permanent factor of life.
- To help clients **resolve emotional and psychological issues** in their lives.
- To help **reduce the stigma** associated with living with HIV/AIDS.
- To help r**educe HIV transmission**.
- To help clients **access the supports and services** they need to stay healthy.

These goals are all part of counselling aimed at **beneficial disclosure**.[1] Disclosure is a neutral term — not good or bad in or of itself. However, the purposes and consequences of disclosure may be beneficial or harmful. Beneficial disclosure describes situations where **an HIV-positive person tells a sexual or injecting drug partner about his or her HIV status for prevention purposes, or discloses to family, community members or health care workers to get support**. Harmful disclosure involves cases where disclosure is made without the consent of the person who is HIV-positive. The disclosure may have adverse consequences for him or her. He or she may face discrimination, abandonment, physical violence, lose his or her job or housing.

Incorporating Legal and Ethical Principles into Counselling Practice

Confidentiality and Consent

Confidentiality is as much an **ethical principle of counselling** as it is a **legal obligation**. The high level of importance assigned to confidentiality stems

directly from the powerful role the counsellor plays in the client's life. Confidentiality is meant to ease the possible challenges that a client may face so as to permit them to feel safe in expressing painful or difficult experiences.

As a general rule, the legal and ethical duty of confidentiality that a counsellor owes to a client prohibits the counsellor from disclosing the client's HIV status (or any other personal information) to a third party without first getting the client's consent to do so. There are legal and ethical exceptions to this general rule. Therefore, a client has a right to know at the outset of the counselling relationship how a counsellor and community based AIDS organization (CBAO) will treat his or her personal information.

For further information on the legal and ethical duties of confidentiality, and the situations where the duty of confidentiality owed to a client can or must be breached, see Chapter 7 (Client Confidentiality and Record-Keeping).

Preventing Harm To a Third Party

Virtually all counselling bodies in the world, in their respective codes of practice, oblige counsellors to take all reasonable steps (including, where necessary, breaking confidentiality) to prevent a client from harming a third party identified to the counsellor by the client. Many codes of practice also include an obligation to act on the client's threat to physically harm him or herself. **However, these codes of practice are not law and they do not take precedence over the legal duties a counsellor owes to each client.**

Chapter 7 (Client Confidentiality and Record-Keeping) contains information about counsellors' obligation to take steps to prevent harm to a third party.

Legal and Ethical Counselling Standards

The checklist below sets out <u>suggested</u> minimum standards for counselling PHAs about HIV disclosure. By using this checklist, counsellors will be providing PHAs with information PHAs are entitled to have when making decisions about disclosing personal information to a counsellor.

When counselling a client, a counsellor should:

- Determine whether there are mental or emotional health issues that may prevent the client from fully understanding his or her rights and responsibilities regarding confidentiality, the criminal law and HIV disclosure.
- Advise the client about his or her legal obligations under the criminal law regarding HIV disclosure.
- Explain to the client the organization's confidentiality policy and record-keeping policies. Wherever possible, offer the client copies of these policies if the organization adopted such policies.
- Inform the client about the limits on confidentiality in the counselling relationship. The client should be told that his or her personal information <u>might</u> be disclosed without consent under a search warrant or subpoena (a type of court order).
- Explain to the client how the organization would respond if client information is sought under a search warrant or subpoena.
- Inform the client whether or not, and if so under what circumstances, the CBAO would disclose client information without consent in order to prevent harm to another person.

These suggested counselling standards do not represent a "gold standard", since it is not possible to anticipate every circumstance in which issues related to disclosure of HIV-positive status will arise between counsellors and their clients. CBAOs should consider expanding these guidelines to meet the specific needs of their clients.

Suggested Approaches to Counselling Clients about HIV Disclosure Issues

The approaches <u>suggested</u> below do not override law or regulations. They do not tell community-based organizations, and the people who work and volunteer in organizations, what to do or how to do it. And they will not necessarily provide

each organization with a ready-made policy or guideline.

Client Assessment: Preventing HIV Transmission

- Assess potential mental or emotional health issues that may prevent the client from fully understanding the principles of HIV transmission.
- Adopt a harm reduction approach that can respond to the client's reality, needs and desires. Reducing the health risks associated with sexual and injection drug activities may be an appropriate goal of interventions for some clients.
- Acknowledge and accept the specific sexual and drug-injecting culture of the client.
- Assess the client's HIV risk reduction knowledge and skills.
- Explain, as necessary, the principles of HIV transmission.
- Provide information, as necessary, on safer sex, safer injecting practices and other measures to reduce the risk of HIV transmission.
- Provide the tools necessary for safer sex and injecting practices (where available) and clear instructions on how to use them [eg: male and female condoms, lubricant, clean needles, syringes and other injecting equipment].

Acknowledge the Client's Perspective

- Acknowledge that some clients may have difficulty communicating openly and honestly in their personal relationships about issues related to HIV disclosure, sex, and drug use.
- Recognize the real and potential physical and psychological dangers of disclosure facing a client, which may include rejection, discrimination, and violence amongst other challenges.
- Acknowledge that disclosure can be extremely difficult during moments of erotic arousal, while anticipating the experience of injecting drugs, or while being high.
- Encourage the client to address disclosure with potential sexual partners and/or people he or she injects drugs with prior to sexual or injection drug activity that has a risk of transmitting HIV.
- Acknowledge that he or she is entitled to have control over the options around disclosing his or her HIV status to sexual and drug-injecting partners, subject to the qualification that this control may be limited by other people if his or her conduct places these partners at significant risk of HIV infection.
- Recognize the real and potential benefits of disclosure to the client, including enhanced communication, support and acceptance on the part of sexual and/or drug-injecting partners.
- Recognize any potential obstacles to disclosure that may require specific interventions, such as addictions and mental health issues.
- Recognize attitudinal and behavioural barriers that may require longer-term or specialized counselling.
- Refer clients to other social/medical services as necessary and appropriate [eg: doctors, methadone programs, addiction services].

Disclosure Where HIV Exposure is Not an Issue

- Acknowledge that disclosure of HIV status in all situations and to all people is not possible, nor desirable, nor necessary.
- Affirm that the client is entitled to control the disclosure of his or her HIV status.
- The decision of when and how to disclose are important, but sometimes difficult, steps for the client in the disclosure process. Ongoing counselling may help.
- Acknowledge that disclosure is a series of events over a lifetime, which may or may not become easier.
- Examine with the client any potential benefits of disclosing his or her HIV status, particularly to the client's support network, including a spouse, a partner, a family member, or friends and other people involved in the client's life.
- Acknowledge the potential for discrimination and other social harms associated with

disclosure to certain individuals or institutions such as employers, landlords, and insurers.

- Include all other issues that may result from disclosure of HIV status. These could include coming out issues resulting from a change in sexual orientation, immigration status, drug use, and sexual violence to name a few. These issues require acknowledgement and respect.
- Discuss opportunities for skills building or the potential benefits to be had from other counselling approaches.
- Recognize your own biases and seek consultation/clinical supervision outside the counselling relationship to address these.
- Refer to other sources of expertise if appropriate.

Counselling is Part of Comprehensive Care

Counselling can help clients live with HIV and explore issues about disclosure of their HIV-positive status. Following the counselling standards and approaches suggested in this chapter may help counsellors provide respectful, supportive, non-judgmental counselling services for PHAs who experience difficulties around disclosure. A comprehensive program of care, treatment and support, including information, education and counselling can enhance HIV prevention efforts, reduce the stigma associated with HIV/AIDS and contribute a person's overall physical, sexual, emotional, psychological and spiritual well-being.

1 *Opening up the HIV/AIDS epidemic: Guidance on encouraging beneficial disclosure, ethical partner counselling and appropriate use of HIV case-reporting* (Geneva: UNAIDS, 2000)

Disclosure of HIV Status After *Cuerrier*

7 Client Confidentiality and Record Keeping

This section of the Resource Guide can be used to:

- Learn about the legal and ethical duty of confidentiality that counsellors and community based AIDS organizations (CBAOs) owe to clients.
- Learn about limits to client confidentiality.
- Understand the legal, ethical and practical issues involved in making decisions about disclosing a client's information without consent to prevent harm to another person.
- Develop organizational policies and guidelines regarding client confidentiality and record keeping.

EXAMPLES OF CONFIDENTIALITY AND RECORD-KEEPING POLICIES FROM COMMUNITY BASED AIDS SERVICE ORGANIZATIONS ARE INCLUDED AT THE END OF THIS CHAPTER. CBAOs WHO DO NOT HAVE POLICIES MAY WANT TO USE THESE EXAMPLES AS A POINT OF DEPARTURE FOR DEVELOPING THEIR OWN POLICIES.

The Right to Privacy, the Duty of Confidentiality, and the Rule of Privilege

Privacy is a fundamental right recognized in the Québec Charter of Rights and Freedoms, under the Canadian Charter of Rights and Freedoms, and international human rights law. Governments in Canada can be held accountable for not respecting the right to privacy, unless they have adequate justification for limiting or overriding it.

The **duty of confidentiality** is one way the law protects a person's right to keep their personal information private. From the perspective of people living with HIV/AIDS (PHAs), the confidentiality of personal information is a critically important duty to be followed by those who provide medical or social services to PHAs. This trust should only be breached in exceptional circumstances and under specified conditions. There are both legal and ethical duties of confidentiality. In Canada, the **ethical duty** of confidentiality has been recognized as a **legal duty** for certain professionals.

The **rule of privilege** is a rule of evidence. It prevents the disclosure of confidential information in a legal case, based on policy reasons. Where the rule applies, someone who has confidential information about another person cannot be forced to disclose that information. The person cannot be forced to testify in a legal case about that information, nor can the person be forced to disclose written communications (or other recorded information she or he has) for use as evidence in the case.

The Legal and Ethical Duty to Maintain Confidentiality

All CBAO staff and volunteers owe each client a legal duty to maintain the confidentiality of the client's personal information, including HIV status.

CBAO staff who are members of **regulated professions** (like registered nurses, social workers or psychologists) have a **statutory duty** to maintain client confidentiality. This legal duty of confidentiality is usually found in the provincial and territorial acts and regulations that govern the profession.

Regulated professionals are also subject to an ethical duty of confidentiality. Where a member of a profession breaches the duty to maintain client confidentiality, the **client can file a complaint against the professional with the profession's governing body. The client can also sue the professional and the CBAO in civil court.**

There is also a **common law duty of confidentiality owed by all staff, volunteers and CBAOs to clients** to maintain the confidentiality of clients' personal information. In Québec, where the common law does not apply, the Québec Civil Code and the Québec Charter of Human Rights and Freedoms state that every person has a right to the respect of his or her private life and a right to non-disclosure of confidential information. **Where a staff member or volunteer breaches the duty to maintain client confidentiality, the client can sue the staff member or volunteer (and CBAO) in a civil court.**

Chapter 8 (Civil Liability Issues for PHAs and CBAOs) contains additional information about potential civil liability of counsellors and CBAOs.

Confidentiality and Counselling

Confidentiality is an ethical principle of counselling. Counsellors also owe a legal duty of confidentiality to clients. In the CBAO counselling context, confidentiality means that **a client's personal health information (including HIV status) may only be disclosed under the following limited circumstances:**

- With the **client's consent**.
- As **required by law or an ethical duty**.
  - — CBAOs and counsellors should think about how to respond to legal and ethical demands for disclosure.
- As ***permitted*** **by law or an ethical duty**.
  - — CBAOs and counsellors should think about whether or not (and in what circumstances) they will disclose a client's HIV status to prevent harm to another person.

At the beginning of the counselling relationship, **counsellors should tell clients about the nature and limits of confidentiality**. This may include providing the client with information about the CBAO's record-keeping practices and procedures. It also may include telling clients what the agency will do in situations where the organization is faced with a legal obligation of disclosure (such as a search warrant or subpoena). If the CBAO has a policy (or practice) about when they will disclose a client's HIV status to prevent harm to another person, the client should be told about this as well.

Limits to Confidentiality

There are **three important limits** to confidentiality:

1. Reporting of HIV and AIDS under public health laws.
2. To prevent harm to another person.
3. Under search warrants and subpoenas.

Reporting of HIV and AIDS under Public Health Laws

Usually CBAOs, their staff, and volunteers do not have any obligation under public health laws to report cases of HIV and AIDS. Public health professionals (like physicians and registered nurses) and labs do have legal reporting obligations. If your organization is a multi-service organization that provides HIV-antibody testing or other medical services, some staff members may have reporting obligations. For more information, see Chapter 5 (Public Health Law).

Do Counsellors Have a Legal Duty to Prevent Harm?

What should counsellors do when an HIV-positive client is having unprotected intercourse or sharing injecting needles with a partner and the partner does not know the client is HIV-positive? **This is the most difficult ethical and moral issue for many counsellors and CBAOs**. There are no easy answers. **CBAOs should consider developing policy or guidelines for staff and volunteers if they do not already exist.**

As the law stands in Canada, counsellors **do NOT have a legal duty to disclose confidential information in order to prevent harm to another person**. However, they have the **discretion to do so where specific circumstances exist, reviewed below**. It is up to each organization to decide whether or not it will disclose client information to prevent harm to another person. Where registered professionals with ethical obligations work or volunteer at the CBAO, the organization's decision may be affected by the professional's ethical obligations.

In 1999, the Supreme Court of Canada ruled in ***Smith v Jones*** that a **public safety exception** applies to solicitor-client privilege, releasing the solicitor of the duty to protect the client's confidentiality. Solicitor-client privilege is the highest privilege

The So-Called "Duty to Warn"

When someone is obliged to disclose confidential information to minimize danger or prevent harm to another person, the obligation is commonly referred to as a "duty to warn". The phrase "duty to warn" can be misleading, because harm can often be prevented without directly warning the person who is at risk. Therefore, it is more accurate to refer to a duty to prevent harm to another person. A person who possesses information given in confidence (like a counsellor) may be able to prevent harm to a known person by taking other steps short of disclosing confidential information directly to the person who may be harmed. Where this is the case, the other person has not been "warned" by the counsellor, but the counsellor has fulfilled any duty he or she may have. One example of this is where, after counselling an HIV-positive client and giving the client a chance to disclose to his or her partner, a physician contacts public health. The physician reports to public health that the client's sexual partner may be at risk of HIV infection, so that public health can follow up with the partner. The physician has not warned the partner, so it is more accurate to talk about the **duty to prevent harm** to another person.

recognized by the courts. So, if a public safety exception applies to solicitor-client privilege, **it applies every type of privilege and duty of confidentiality**.

The **public safety exception** to confidentiality seems to **release a counsellor or counselling agency from their civil duty to protect client confidentiality**, if three things can be demonstrated:

1. **There is a clear risk of harm to an identifiable person or group of persons.**
2. **There is a significant risk of serious bodily harm or death.**
3. **There is imminent danger.**

The three conditions of public safety exception pose some particular challenges with regard to confidentiality and HIV disclosure. Public safety generally involves a situation where an HIV-positive person refuses to disclose his or her HIV status to a sexual or drug-injecting partner(s) with whom they are engaging in activities that pose a significant risk of HIV transmission. For confidentiality to be breached the counsellor must be able to identify the partner(s) and the counsellor must be satisfied that the client clearly intends to engage in unprotected intercourse or share unclean drug-injecting equipment with the partner.

The three conditions in *Smith v Jones* are a minimum standard. If the three conditions are not met, a counsellor has no legal authority to disclose client information to prevent harm. Even if all three conditions are present, a counsellor does not have to disclose since there is no legal duty to do so. According to the Supreme Court, there is discretion (ie, permission) to disclose when the three conditions are met. If the decision is made to disclose, the Supreme Court emphasized that the disclosure of the confidential information should be limited as much as possible.

Do Professionals Have an Ethical Duty to Prevent Harm?

Some professional associations have issued guidelines based on the ***Smith v Jones*** case. These guidelines permit members of the profession to breach client confidentiality in order to prevent harm to another person. The Canadian Medical Association and the Canadian Association of Social Workers advise physicians and social workers, respectively, that disclosure to a spouse or sexual partner may be warranted when an HIV-positive client is unwilling to disclose on their own, provided that the partner is actually at risk of HIV infection and the physician or social worker informs the client first of his or her intention to disclose to the partner.

According to these professional guidelines, before breaching confidentiality, the physician or social worker should **intervene through counselling and a discussion of possible barriers to risk reduction in order to motivate the client to either disclose and/or to stop unsafe behaviour**. If these interventions fail, the physician or social worker should **report the situation to public health authorities**.

Disclose to Prevent Harm — A Decision-Making Tree

Where a counsellor knows that an HIV-positive client is putting an identifiable person at risk of HIV infection and that person is unaware of the risk, a **measured response is called for**. If a counsellor does not use a measured approach, and discloses confidential client information as a first step, the counsellor and/or CBAO could face a lawsuit from the client. The CBAO would also run the risk of losing credibility in the community, which could make it more difficult to reach PHAs who could potentially benefit counselling and other services.

If the CBAO has a policy or guideline regarding disclosing client information to prevent harm, then it **should be followed unless there is a valid reason not to do so**. A decision not to follow the policy should be approved by a supervisor or the executive director of the CBAO.

If the CBAO does not have a policy or guideline, we suggest that the counsellor and CBAO take a measured approach. Here is a **decision-making tree** that sets out a measured approach to making decisions about whether or not to disclose client information to prevent harm:

STEP 1:
Seek **guidance** from a supervisor or the Executive Director.

STEP 2:
Answer the following **questions**:

- Has the HIV-positive client has been **thoroughly counselled** about the need to disclose his or her HIV status to sexual and drug injection partners where there is a significant risk of HIV transmission?
- Is **an identifiable person or group of persons** at risk?
- Is the risk a **significant risk of serious bodily harm or death**?
- Is the serious bodily harm or death **imminent**?

STEP 3:
If the answer to any one of these questions is "NO", then there is no legal basis to take action to prevent harm (ie: to disclose the client's HIV status).

If the answer to all of the questions is "YES", then you should **consider**:

- Whether the counsellor has any professional ethical obligations.
- The potential harm that will result if client confidentiality is breached [to the client, to the counselling relationship, to the ability of the organization to carry out its mandate].
- The potential harm [to the client's partners, to the ability of the organization to carry out its mandate] that will result if client confidentiality is not breached.
- Whether the harm of disclosing outweigh the harm of not disclosing or vice versa.

STEP 4:
If after weighing these factors, you **decide not to breach** client confidentiality, you should continue to counsel the client about the legal obligation to disclose his or her HIV status to sex and injecting partners who are at significant risk of HIV transmission.

If after weighing these factors, you **decide to breach** client confidentiality, then you should consider the steps you will take **while continuing to protect your client's rights and well being to the greatest possible extent**. You should:

- Decide who you are going to contact, when and what client information you are going to disclose.
- Give the client reasonable advance notice, and discuss the procedure you are going to follow and the information you are going to disclose.
- Help the client develop a plan to deal with potential negative consequences associated with disclosure.

STEP 5:
Once this has been done, you are in a position to undertake disclosure. When doing so, remember:

- As you attempt to prevent the harm to the other person, you have an ongoing legal obligation of confidentiality to **disclose as little information as possible** to accomplish the goal of preventing harm.
- Never reveal the client's identity to his or her partner directly. Satisfy yourself that anyone you are giving information to also knows the importance of not revealing the client's identity.

The decision-making tree **can also be used by CBAOs to develop policy, guidelines or positions on the issue** of having to turn to disclosure to prevent harm to another person.

Search Warrants and Subpoenas

Search warrants can be used by police officers in the investigation of criminal or other types of offences to **look for and seize records, including counselling records**. A search warrant is obtained from a **justice of the peace** on the basis of sworn evidence from a peace officer (Criminal Code section 487(1)). Under the Criminal Code, prior to issuing the warrant, the justice of the peace must have **reasonable grounds to believe that evidence exists with respect to commission of an offence** under the Code or in another federal statute. In exercising his or her discretion, the justice of the peace must balance the privacy interests of the individual in a democratic society against the interest of the state in investigating and prosecuting crimes.

Under the Criminal Code, a **court can issue a subpoena** to any person who is likely to have material **evidence about a criminal case** (Criminal

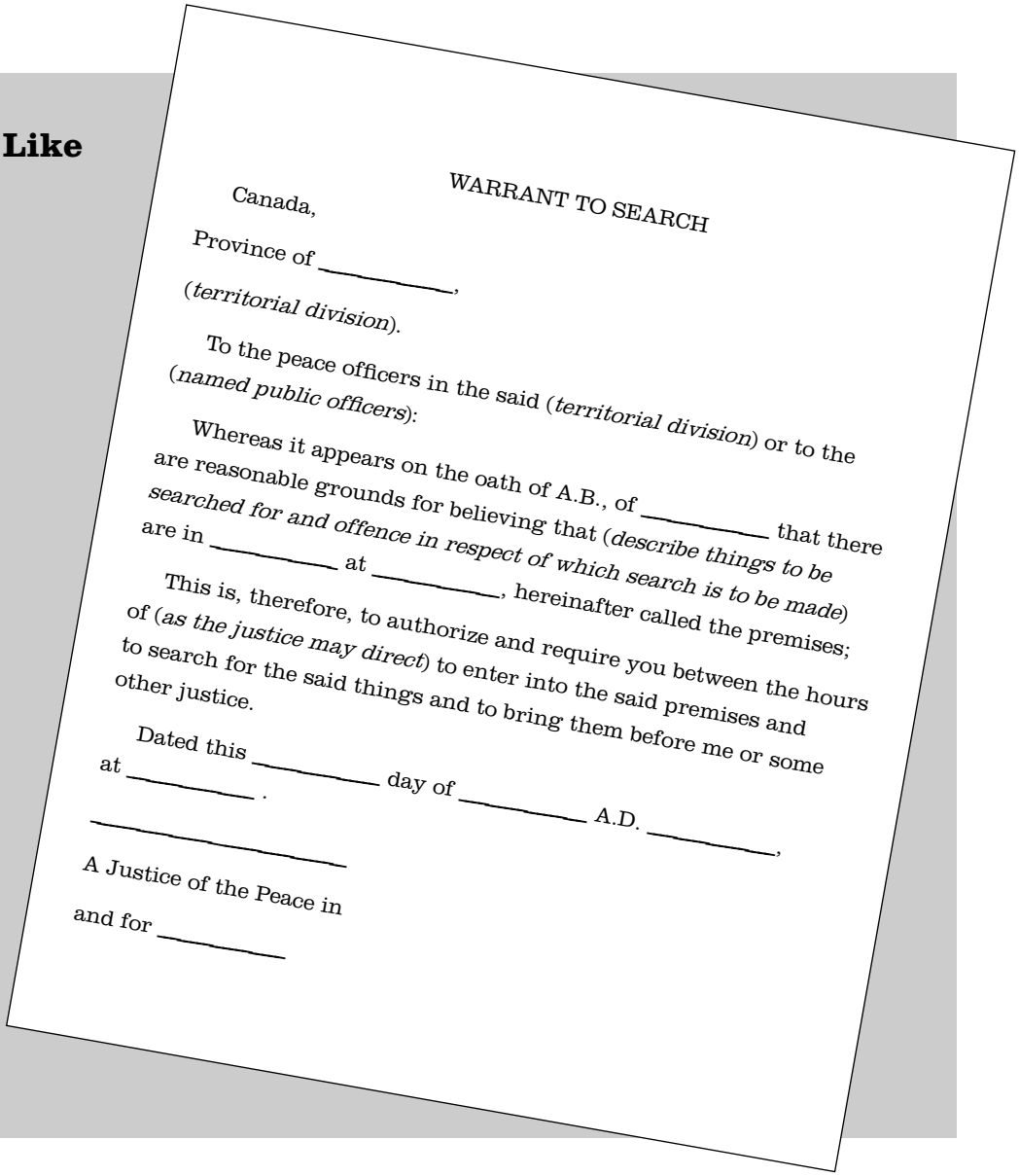
Code section 697 to 708). A subpoena is an order of the court requiring a person to attend court to give evidence at a time and place stated in the subpoena. The subpoena can also require the person to bring anything in his or her possession or control that is relevant to the criminal proceedings. This would **include a client's counselling records**. A person who fails, without lawful excuse, to attend these proceedings is guilty of **contempt of court**, and the court can issue an arrest warrant for the person.

Legal Protection for Client Records and Information

Canadian law does not automatically protect counselling or even medical records from being seized by police under a warrant or being introduced as evidence in criminal court under a subpoena. A counsellor (or CBAO) can try to prevent client information from being used as evidence in a criminal investigation or prosecution by asserting "privilege" over the confidential information, or by making legal

What a Search Warrant Looks Like

FORM 5
(Section 487)



WARRANT TO SEARCH

Canada,

Province of _____,

(*territorial division*).

To the peace officers in the said (*territorial division*) or to the (*named public officers*):

Whereas it appears on the oath of A.B., of _____ that there are reasonable grounds for believing that (*describe things to be searched for and offence in respect of which search is to be made*) are in _____ at _____, hereinafter called the premises;

This is, therefore, to authorize and require you between the hours of (*as the justice may direct*) to enter into the said premises and to search for the said things and to bring them before me or some other justice.

Dated this _____ day of _____ A.D. _____, at _____ .

_____

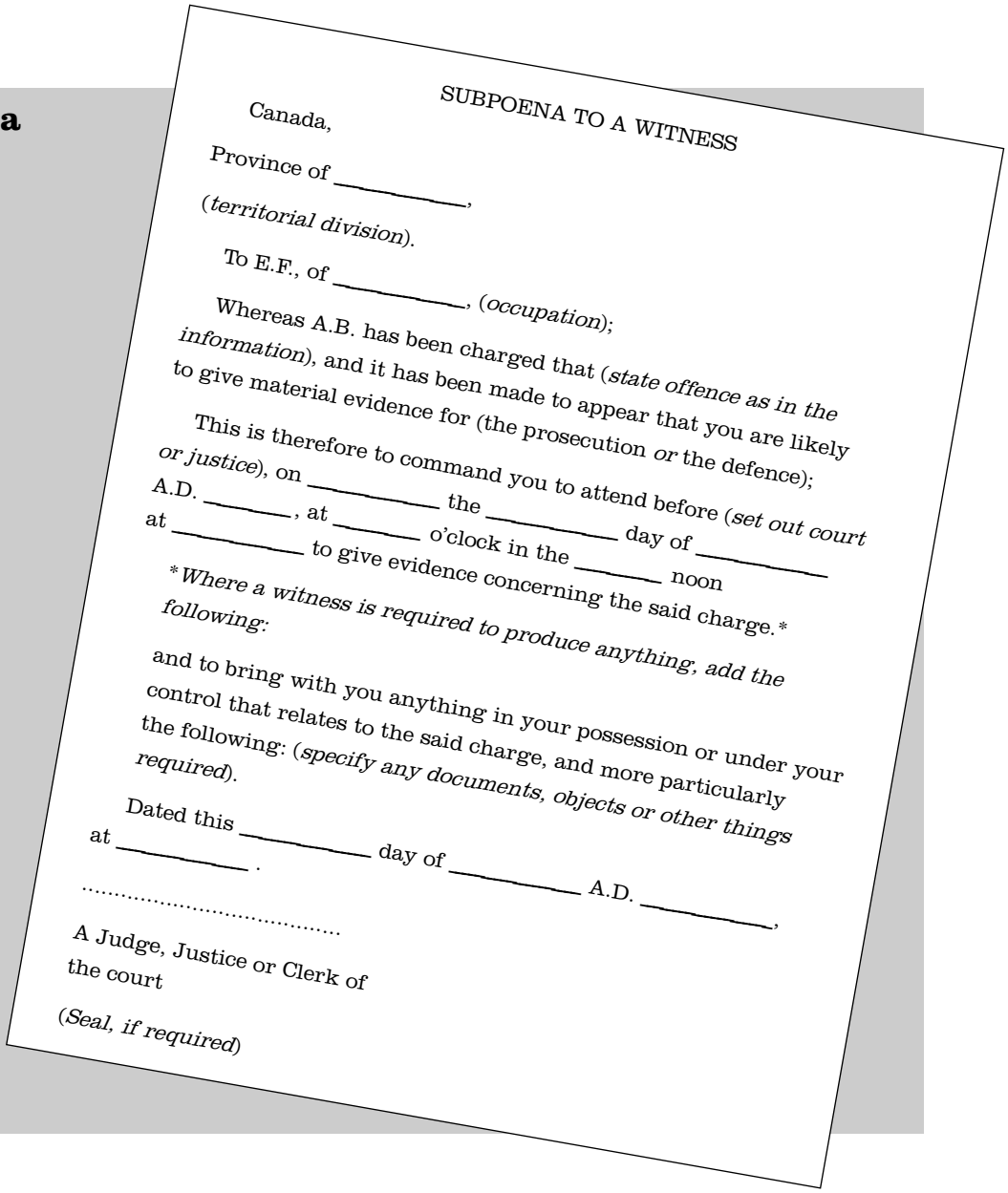
A Justice of the Peace in and for _____

arguments based on rights under the Canadian Charter of Rights and Freedoms:

- Section 7 of the Charter provides that, "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice". The section 7 rights to liberty and to security of the person protect privacy interests.[1] Justice Wilson wrote in ***R v Morgentaler***, "the liberty interest is rooted in fundamental notions of human dignity, personal autonomy, privacy, and choice in decisions regarding an individual's fundamental being".[2]
- Section 8 of the Charter states that: "Everyone has a right to be secure against unreasonable search or seizure". This means that search or seizures conducted by the police or other state actors must conform to Charter principles. The constitutional interest in privacy under

What a Subpoena Looks Like

FORM 16
(Section 699)



SUBPOENA TO A WITNESS

Canada,

Province of _____,

(*territorial division*).

To E.F., of _____, (*occupation*);

Whereas A.B. has been charged that (*state offence as in the information*), and it has been made to appear that you are likely to give material evidence for (*the prosecution or the defence*);

This is therefore to command you to attend before (*set out court or justice*), on _____ the _____ day of _____ A.D. _____, at _____ o'clock in the _____ noon at _____ to give evidence concerning the said charge.*

**Where a witness is required to produce anything, add the following:*

and to bring with you anything in your possession or under your control that relates to the said charge, and more particularly the following: (*specify any documents, objects or other things required*).

Dated this _____ day of _____ A.D. _____, at _____ .

.....

A Judge, Justice or Clerk of the court

(*Seal, if required*)

section 8 seeks to prevent unjustified searches by the state. The Supreme Court has stated on several occasions that section 8 of the Charter should be broadly construed to give effect its purpose, that is, to ensure the citizen's right to a reasonable expectation of privacy, and to prevent unjustified searches by the state.[3] The content of the section 8 protection for individuals was elaborated by Justice Sopinka in ***R v Plant***:

> In fostering the underlying values of dignity, integrity and autonomy, it is fitting that section 8 of the Charter should seek to protect a *biographical core of personal information which individuals in a free and democratic society would wish to maintain and control from dissemination to the state*. This would include information that tends to reveal intimate details of the lifestyle and personal choices of the individual.[4] [emphasis added]

The legal principle of **privilege** is a **common law rule of evidence whereby certain communications are not admissible as evidence in court proceedings for policy reasons**. Particular social values are "of such importance that [they] cannot be sacrificed to ascertain the truth in litigation."[5] It is up to a witness or a party in a proceeding to claim privilege for the communication that is sought as evidence. Privilege may confer absolute or partial protection from disclosure.[6] The common law principle of privilege applies in criminal matters throughout Canada, because criminal law is a federal government responsibility.

1. A court must determine on a **case-by-case basis** whether confidential information given to a counsellor is admissible as evidence in court. The Supreme Court has adopted a four-part test to determine whether case-by-case privilege applies in a particular circumstance (known as the Wigmore criteria):
    1. the **client disclosed the information in confidence** that it would not be divulged;
    2. the **confidentiality must be essential** to the relationship;
    3. the **community believes** that the relationship should be protected and fostered; and
    4. **disclosing the information would do more harm** to the relationship than the benefit gained by deciding the legal case correctly based on more information.[7]

Responding to Search Warrants

CBAOs, and counsellors who are bound by professional legal and ethical obligations, will have to decide for themselves how to respond when faced with a search warrant. Whether the CBAO or counsellor challenges the seizure of client records is a matter of principle and resources. Some organizations may feel strongly that breaching confidentiality will undermine the trust relationship with the community they serve and ultimately damage their ability to support PHAs.

The sealing of client records and the assertion of privilege are legal actions that demonstrate that an agency or organization is opposed to the search warrant and may challenge the seizure of the records in court. It also gives the client an opportunity to challenge the seizure by police.

Where the police demand a client's counselling or other records such as HIV test results and medical files under a search warrant, **CBAOs that wish to challenge the seizure** should:

- Consult the CBAO's policy and guidelines on Client Confidentiality and Record-keeping, if they exist.
- Ask to see their warrant. Examine the warrant to make sure a justice of the peace has signed it and that it relates to the records the police have asked for.
- Ask the police exactly what records they want.
- Locate the records for the police and place them in an envelope and seal the envelope. Write on the envelope: **PRIVILEGE ASSERTED — DO NOT OPEN.**
- Tell the police: **I AM ASSERTING THAT THESE RECORDS ARE CONFIDENTIAL AND PRIVILEGED AT LAW.** If the police object or appear to doubt you, tell them you are **relying on the principles set out in**

section 488.1 of the Criminal Code that apply to law office searches.

- Tell the police the name, address and telephone number of the CBAO's lawyer, if known. Say to the police: **WE WILL BE INSTRUCTING OUR LAWYER TO BRING A MOTION TO A JUDGE AS SOON AS POSSIBLE**. These motions must be brought promptly and no later than fourteen days after the seizure of the records.
- Give the records to the police. They will take them away.
- **Call the client immediately.** Advise him or her of the seizure and suggest that he or she seek legal advice providing appropriate referrals.
- Call a lawyer as soon as possible to get legal advice.

Even if the CBAO and counsellor decide not to challenge the seizure of the client's records, the CBAO or counsellor should **call the client immediately**. Advise him or her of the seizure, and suggest that he or she **seek legal advice**. Provide **appropriate referrals** (for example refer the client to a criminal lawyer, lawyer referral service, legal aid office, legal clinic, or legal advice service).

Responding to Subpoenas

When served with a subpoena, CBAOs and counsellors must consider whether or not they are going to claim that the client's records and other information should not be introduced as evidence. In other words, they must decide whether they are going to assert privilege over the potential evidence. Here are some things to consider:

- As a first step, consult the CBAO's policy and guidelines on Client Confidentiality and Record-keeping, if they exist.
- Next, the CBAO (or counsellor) should **contact the client** and advise him or her of the subpoena. Suggest to the client that he or she seek legal advice. Provide appropriate referrals (eg: a criminal lawyer, lawyer referral service, legal aid office, legal clinic, or legal advice service).
- The CBAO or counsellor should consider **seeking legal advice**.

The Ontario Court of Appeal has indicated that shredding records is "manifestly inappropriate."[8] People who destroy records after being served with a subpoena may be cited for contempt of court and, upon conviction, subject to a fine or imprisonment.

Record Keeping

Every **client should be told** that any information they disclose to a counsellor could **conceivably be used against him or her in a criminal investigation or prosecution**. Clients should also be given information about the counsellor/CBAO note-taking and record-keeping practices and policies.

CBAOs may also want to consider what information is recorded in client counselling files. Counsellors who are members of regulated professions are required by law to keep records of their professional practice, in accordance with the generally accepted standards of practice of their profession. Laws and professional standards often set out the minimum information that must be recorded, and rules about access, disclosure, storage and destruction of client records. Where a regulated professional fails to keep a record, or handles a record in a way that is prohibited, he or she may be guilty of professional misconduct.

Some community based agencies have decided to reduce note-taking to a minimum level to limit the potential for client notes to be used as incriminating evidence against the client. For example, some rape crisis and sexual assault centres have taken this step to protect clients who may become witnesses in criminal prosecutions. In these agencies, counsellors record general feelings expressed by the client only and avoid recording facts (called non-fact based reporting). Some health educators have recommended that this procedure be adopted with files of HIV-positive clients as well.

Reducing note taking to a minimum (or not taking any notes) involves difficult trade-offs for CBAOs. It may unnecessarily undermine the counselling relationship and may have the unintended effect of compromising the agency's legal position in a case involving the client. Agencies may need to demonstrate that they have advised a client

thoroughly and accurately regarding transmission and other issues related to HIV. In the case of someone with HIV who continues to engage in unsafe behaviour, the agency might need to show that it had taken every reasonable step possible to encourage the client to practise safer behaviour. A minimal note taking policy could undermine the agency's ability to do this. Detailed counselling notes may also provide better continuity in client counselling, particularly when a client has more than one counsellor.

[1] See *R v Morgentaler*, [1988] 1 S.C.R. 30, R v O'Conner, [1995] 4 S.C.R. 411, R v Mills, [1999] 3 S.C.R. 668.

[2] *R. v. Morgentaler*, note 174.

[3] See for example *R v Buhay*, [2003] SCC 30 at para 18; *R v Colarusso* (1994), 110 D.L.R. (4th) 297 (S.C.C.) at 319; *Hunter v Southam*, [1984] 2 SCR 145 at 159.

[4] [1993] 3 S.C.R. 281 at 293.

[5] Watt, D. *Watt's Manual of Criminal Evidence 2001* (Toronto: Thomson Canada Limited, 2001) at 110–111.

[6] *M(A) v Ryan*, [1997] 1 SCR 157 at paras 18, 33.

[7] *Slavutych v Baker*, [1976] 1 SCR 254.

[8] *R v Carosella* (1995), 102 CCC (3d) 28 (Ont CA).

Guidelines on Confidentiality of Personal Health Information

Ontario Advisory Committee on HIV/AIDS
June 2002

General

1. The term "personal health information" includes any information spoken or recorded (on paper, in an electronic format or in any other form) that relates to the physical or mental health or health care of an identifiable person who is a past or present client of <insert agency name>. Personal health information does not include anonymous information that cannot be manipulated or linked to other data that would identify the individual.
2. This policy applies to personal health information collected by <insert agency name> at its permanent site and all of its outreach sites (if applicable). <Insert agency name> shall designate an individual or individuals responsible for ensuring that the staff of the organisation comply with this policy.
3. The purposes for which personal health information is collected shall be identified by <insert agency name> at or before the time the information is collected, and those purposes shall be communicated to the client. Clients should be made aware of how their information will be handled and may be given a copy of this policy.
4. The collection of personal information shall be limited to that which is necessary for the purposes identified by the organisation. Personal health information shall not be collected from clients by <insert agency name here> if it is not necessary for the purpose of delivering services to the client.
5. If sometime after personal health information is collected by <insert agency name here>, the organisation wishes to use the information for a purpose different than that for which it is collected, the organisation shall not do so without first obtaining consent to the new use of the information from the client.
6. Personal information shall be as accurate, complete, and up-to-date as is necessary for the purposes for which it is to be used. The client shall be able to challenge the accuracy and completeness of the information and have it amended as appropriate.
7. <insert agency name> will maintain the confidentiality of all personal health information relating to its clients. Personal health information will not be collected, used or disclosed by <insert agency name> except under the following limited circumstances:
    - disclosure to the client;
    - disclosure, use or collection with the client's consent;
    - as required by law.
8. (For use by designated Anonymous Testing sites only) <insert agency name> is designated as an anonymous HIV testing site under the Health Protection and Promotion Act. HIV testing and counselling charts are therefore maintained on an anonymous basis, meaning that only the client has the ability to link his or her HIV test result and related counselling record with his or her identity.

9. Client charts for ongoing medical and/or psychosocial care provided by <insert agency name> are maintained using names, and contain other personally identifying information. Detailed counselling notes should be made and kept in the client's file.

10. <insert agency name> maintains all HIV testing and counselling records and client charts in closed cabinets that are locked when the agency is not in operation. Ideally, such cabinets will be in a locale within the agency that is not normally accessible to the general public.

Disclosure of personal health information to clients

11. A client may view his or her chart on the premises of <insert agency name here> without charge. He or she may also obtain a copy of his or her chart. <insert agency name> may require reasonable notice to respond to a request for a copy of the chart, and may charge reasonably for the cost of photocopying it.

12. A client who is unable to return to the agency to obtain test results or other personal health information may be informed by telephone. With STD results, the client will be asked for either a code or date of birth as a means of identification. With anonymous HIV test results, the client must provide a unique identifier (i.e. a numbered code or code word) which will be recorded in the chart as a means of identification. This must be arranged while the client is at the agency.

Disclosure to health care providers

13. Within <insert agency name>, personal health information relating to a client may be shared as between members of the organisation's staff (including both physician and non-physician staff) only if necessary to achieve the purpose for which the information was collected, but without the need for a signed consent form.

14. Personal health information relating to a client may be shared with a health care provider who is not a member of the agency's staff only on the basis of informed consent. If the sharing of the information is for the purposes of making a referral, and the client has consented to the referral process in advance, then written client consent is not required. Otherwise, a written consent form that specifies what information is to be released and to whom, that is signed by the client, witnessed and dated, should be obtained. Consents to the release of information should be time limited and an expiry date for the consent should appear on the face of the consent form.

Disclosure to an authorised representative of the client

15. Personal health information relating to a client may be disclosed to an authorised representative of a client (for example a client's lawyer) only on the basis of a consent form that specifies what information is to be released and to whom, and is signed by the client, witnessed and dated. <insert agency name> may seek confirmation of the authority of the personal representative.

16. <Insert agency name> will not release personal health information to an attorney under a power of attorney without ascertaining the validity of the power of attorney. If the document in question is a continuing power of attorney for personal care, <insert agency name> will not release personal health information without first ascertaining that the client is incapable of consenting to the release of the information due to mental incapacity.

17. <insert agency name> may charge the client's representative for photocopying and delivery (if applicable).

Disclosure in response to a summons or other court application

18. Written records may be subject to disclosure obligations imposed by law (for example, if the client is or becomes involved in court proceedings to which that information is relevant). In addition, staff can be summonsed to testify about oral conversations with clients.

19. <insert agency name> will not disclose personal health information immediately upon receipt of a summons or other court application.

20. If <insert agency name> receives a summons or other court application seeking the disclosure of personal health information, all related records will be removed from regular use, placed in a sealed envelope and hand delivered to <insert agency name>'s lawyer as soon as possible.

21. <insert agency name>'s lawyer will determine whether <insert agency name> is in proper receipt of the summons or other court application, and will use best efforts to ensure that the client to whom the records relate is notified that the summons or other court application has been received by <insert agency name> and of its contents so that he or she may take steps to protect his or her privacy interests.

22. <insert agency name> will determine its position as to the disclosure of the personal health information at issue considering the interests of the client, the agency and the applicable law (on the advice of its lawyer).

23. <insert agency name>'s lawyer will attend before the court (or other appropriate decision maker) to make submissions as to whether the sealed records should be disclosed by <insert agency name> and, if so, to what extent.

AIDS COMMITTEE OF TORONTO
HUMAN RESOURCES MANUAL
POLICY 1-50
CONFIDENTIALITY

The AIDS Committee of Toronto (ACT) respects the right to privacy and honours the confidentiality of current, former and prospective: service users, volunteers, Board members, members, donors, sponsors and employees.

CONFIDENTIALITY STATEMENT

All employees, volunteers, students, Board members, and other individuals with access to confidential and privileged information are required to sign a confidentiality statement before commencing duties at ACT.

The obligation to maintain confidentiality applies to the duration of the contact with ACT and continues indefinitely after the relationship with ACT has ceased.

CONFIDENTIAL INFORMATION

Confidential information includes but is not limited to the following:

1. Personal service user information disclosed to ACT including:

   — identity;

   — the fact that an individual is a current, former or prospective service user of ACT;

   — diagnosis or medical condition;

   — family relations;

   — sexual orientation; and

   — phone number or address.

   The above includes service users who may also be employees or volunteers.

   Service user includes any individual who provides personal information to ACT or consents to a third party providing such information to ACT in connection with services received or anticipated to be received. Service user includes prospective, current and former service users.

   Service user information may not be disclosed to a partner, family member or friend without the express permission of the service user. (See Disclosure/Release of Information to Others, PS # 3-50.) If requesting information about a person known to ACT, these individuals are to be directed back to the person about whom they were enquiring.

2. Employee personnel matters.

3. ACT business issues (e.g., media launches, financial information).

4. Information regarding volunteers except as otherwise outlined in Confidentiality of Volunteer Information, HR # 9-110.

5. Information regarding donors.

6. Mailing lists and telephone numbers compiled of prospective, current or former: service users, employees, contributors, volunteers, sponsors and donors are confidential and are not to be shared without the express written permission of the persons involved or of the Executive Director or his/her designate. Should any information be released without express permission of the persons involved, the Executive Director or his/her designate must notify the Board of such occurrence at the subsequent meeting of the Board of Directors.

ACCEPTABLE INFORMATION SHARING

(See Disclosure/Release of Information to Others, PS # 3-50.)

BREACH OF CONFIDENTIALITY

It is a breach of confidentiality to:

1. Discuss any confidential information within or outside ACT where it may be heard by individuals who are not authorized to have access to that information.

2. Provide confidential information or records to unauthorized individuals.

3. Leave confidential information in written form or displayed on a computer terminal in a location where it may be viewed by unauthorized individuals.

If a breach of confidentiality is identified, this is to be reported to a supervisor and if appropriate, Progressive Discipline, HR #'s 8-20 and 8-21 is followed.

CONFIDENTIALITY BY SUPPORT GROUP MEMBERS

(See Support Groups: Confidentiality by Members, PS # 4-20-40.)

AIDS COMMITTEE OF TORONTO
PROGRAMS AND SERVICES MANUAL
POLICY 3-20
RECORDING REQUIREMENTS/GUIDELINES

PURPOSE OF RECORD

The purpose of the clinical record is to:

— document the assessment and counselling process with clients;

— reflect recognized standards of practice;

— communicate effectively with internal staff and other professionals as required; and

— assist in summarizing, organizing and guiding the service delivery process.

OVERALL REQUIREMENTS

1. A new profile sheet is initiated for each new client in the AIDS Committee of Toronto (ACT) Client Services database.
2. A counselling log must be maintained for all active clients. Demographic information, presenting issues, and action taken must be entered.
3. Counselling notes should be written clearly and concisely, keeping in mind that the client, other staff, and other professionals outside the agency may read the record.
4. Counselling notes should be brief with supporting facts as needed. Impressions and opinions should be identified as such and kept to a minimum.
5. Each entry is to be dated.

AIDS COMMITTEE OF TORONTO
PROGRAMS AND SERVICES MANUAL
POLICY 3-30
SECURITY OF CLIENT RECORDS

Client records are the property of the AIDS Committee of Toronto (ACT).

Employees and volunteers of ACT are to:

1. ensure that client personal information is kept safe and secure,
2. safeguard the security of client records, and
3. keep existing paper files in lockable filing cabinets. Staff are responsible for ensuring that filing cabinets are locked at the end of each working day. Staff requiring access to files after hours are responsible for locking cabinets after use. Keys for cabinets are to be kept in a secure location in each area.

When necessary to transport a file, the file must be enclosed in a sealed envelope and transported in a secure manner while on route to destination, e.g., in locked trunk or on person.

(Also see Facsimile, AM # 2-60; Security, AM # 3-40; Confidentiality, HR # 1-50; Client Access to Client Information, PS # 3-40; Disclosure/Release of Information to Others, PS # 3-50.)

AIDS COMMITTEE OF TORONTO
PROGRAMS AND SERVICES MANUAL
POLICY 3-50
DISCLOSURE/RELEASE OF INFORMATION TO OTHERS

Client personal information may be disclosed or released to other parties only under one or more of the following conditions:

1. Client personal information may be disclosed with the explicit informed consent or waiver of the client. When deemed necessary, this consent should be obtained in writing.
2. Client personal information may be shared among employees and/or volunteers of the AIDS Committee of Toronto (ACT) to the extent necessary to render proper and effective services to clients.
3. a) When ACT refers clients to other service agencies, the client's written consent is required before personal/confidential information is shared with personnel of the other agency.

   b) When a client is referred to ACT by another agency/service, the client's written consent is also required before personal/confidential information may be shared with that referral source.
4. When a client would benefit from the services of another agency and a referral is made, ACT may with the client's verbal consent, follow-up with that agency to ascertain the outcome of the referral.
5. Management staff may access client personal information as may be required to ensure effective supervision of employees or volunteers.
6. Confidential information may be shared (with or without the individual's consent) in some situations which require immediate action to prevent harm, such as, preventing a harmful criminal activity or assisting a mentally incompetent person who refuses to seek needed medical attention.
7. ACT may disclose personal client information to the extent necessary to defend the agency, its officers, employees or volunteers from any claim or lawsuit instituted against ACT, its officers, employees or volunteers, by or on behalf of a client or the client's heirs, executors or assigns, including any claim brought by a client's insurers.
8. ACT may disclose client personal information where required by law to do so.
9. Upon presentation of a subpoena, required confidential information is provided by the Executive Director/designate to the court. Prior to attending with the required documents, the documents are to be copied and copies retained at ACT. Only required information is to be released. The Executive Director must seek advice of legal counsel.
10. Statistical information or data may be disclosed provided no identifying data also supplied.

HIV/AIDS REGIONAL SERVICES

Number: 4.00

Policy: Confidentiality

Effective Date: March 9, 1998

Revision Dates: June 5/00, June 2002

4.01 Principles

Through the course of volunteer or paid work with HARS, certain facts of a highly personal nature about individuals who are part of the organization or service users will be learned. Examples of such information include: names, medical condition and treatment, finances, living arrangements, employment, sexual orientation, and relations with family members.

All volunteers and staff are expected to maintain confidentiality of all such information unless authorized by HARS and have specific consent by the individual to whom the information pertains or is required by law.

4.02 Policy

All representatives of HARS, employees and volunteers shall be made aware of the principles of confidentiality and related personnel policies, during board/staff/volunteer orientation. Compliance with corporation policy regarding confidentiality shall be adhered to.

All corporation personnel (Board members, staff, volunteers) are required to sign a form which indicates that they have been informed and understand the confidentiality policy (see Appendix E, Confidentiality Form).

Confidentiality extends for the duration of service contact and indefinitely once the working relationship with HARS has ceased.

A breach of confidentiality may result in the termination of those involved, either an employee or a volunteer.

4.03 Guidelines

1. Working notes kept by HARS personnel may contain confidential information regarding service user associations with HARS services. For this reason all notes are considered confidential information and must be handled in a manner consistent with the confidentiality policy.
2. Disclosure of confidential information may only occur when informed written consent has been obtained from the individual or when HARS has been subpoenaed by court, or mandated by law to report, or to appropriate authorities, in exceptional circumstances. (See Appendix F)
3. Events with respect to service users or within the organization, which have an impact on the functioning of HARS, or a part of HARS, shall be shared internally by the Board or by the Executive Director, as policy states. (Also see APPENDIX F)
4. Service user files will be kept in a locked filing cabinet to ensure confidentiality.

   Service user files are the property of HARS. Service users may have access to their files with reasonable notice. If a service user wishes to have a copy of his/her file, it will be provided by HARS within a reasonable time frame.
5. Standard Service User forms see Appendix "K"

APPENDIX "E"

Confidentiality Form

Through the course of your volunteer/staff work with HIV/AIDS Regional Services (HARS), you may learn certain facts of a highly personal and confidential nature about individuals who are part of the Services or clients. Examples of such information include: names, medical condition and treatment, finances, living arrangements, employment, sexual orientation, and relations with family members.

THE DECLARATION

I have been made aware of the confidential nature of information concerning members of HIV/AIDS Regional Services and of clients. Whether it may become available to me in the normal performance of my duties or inadvertently, I agree to exercise all the reasonable care as to not disclose such information unless I am authorized by HARS and have specific consent by the individual to whom the information pertains or I am required by law.

Signature	Date
Name (please print)	Witness

APPENDIX " F "

HARS Disclosure of Confidential Information 03/00

The contents of this document must be explained to all service users, preferably during the intake process.

In general, information shared by service users is considered confidential and will only be shared internally with the Executive Director and other Support Services staff on a "need to know" basis. Please refer to the Confidentiality Policy #4 of the HIV/AIDS Regional Services Policy & Procedures Manual, where it states:

"Disclosure of confidential information may **only** occur when informed consent has been obtained from the individual or when HARS has been subpoenaed by court or mandated by law or to appropriate authorities, in exceptional circumstances. (see Appendix F)" 4.03.2

Exceptional circumstances refer to situations involving safety.

1. One such circumstance is outlined within the Suicide Prevention Policy #26.
2. Another such circumstance is one in which HARS staff have *reasonable belief* that a service user has and/or plans to, in the future, seriously harm another individual.** The following procedure will be followed:
   - Staff will advise the Executive Director of the details. Factors to be considered in reaching a decision about contacting appropriate authorities include:
     — The actions, their impact or consequences;
     — The intended actions;
     — Whether the behaviour is deliberate, repeated or malicious;
     — What the actions are motivated by;
     — The openness and willingness of the service user to work with community supports;
     — The limitations and the ability of the service user to change his/her behaviour;
     — How imminent the danger or harm is;
     — What attempts the service user has made to reduce risks associated with particular behaviours.

• The Executive Director, after consulting with staff, may consult with members of the Board Executive or a third party, e.g. another manager of an *ASO*, another Executive Director, a lawyer. No identifying information would be shared during such consultation.

• Should a decision be reached to disclose to an authority, effort will be made to notify the service user, in question, of this action.

• The Executive Director, or designate, will contact the appropriate authorities.

** Anonymous reports do not constitute "reasonable belief" or grounds requiring HARS to follow-up. Anonymous callers will be told that they can report their concerns to the local Public Health Unit.

Disclosure of HIV Status After *Cuerrier*

8 Civil Liability Issues for PHAs and CBAOs

This section of the Resource Guide can be used to:

- Learn about the basic legal principles of civil liability.
- Learn about the potential civil liability of people living with HIV/AIDS (PHAs) for not disclosing his or her HIV status.
- Counsel clients about civil liability issues.
- Learn about the potential civil liability of counsellors and community based AIDS organizations (CBAOs) for not disclosing a client's HIV status to prevent harm to someone else.

Learn about the potential civil liability of counsellors and CBAOs for disclosing a client's HIV status without the client's consent.

- Understand how having policies and guidelines can limit the potential civil liability of counsellors and CBAOs.

Civil Liability

Civil liability is the area of law concerned with private responsibility between persons. The **persons** involved in a civil court case can be **natural persons** (in other words, human beings) or **legal persons** (like corporations and governments). The word **party** is often used to refer to the persons involved in a civil court case.

The party who files a lawsuit is known as the **plaintiff**. The party against whom the lawsuit is filed is known as a **defendant**. The standard of proof in a civil court case is **proof on a balance of probability**. This is a lower standard of proof than in criminal cases, which must be proved beyond a reasonable doubt. In civil court cases, a party who is found to have breached a legal duty may be liable to pay monetary compensation to a party who has suffered damage, or be subject to other court orders or restraints.

A CBAO that is incorporated has a legal personality and can be sued. As well, the staff, volunteers and directors of CBAOs can be sued personally, whether or not the CBAO is incorporated. Some CBAOs have directors' liability insurance, or otherwise indemnify the directors, to protect the personal assets of their directors from being used to pay legal fees, court costs and court-ordered monetary awards.

Two sources of law form the basis of civil liability in provinces and territories other than Québec. The first source of law is the **common law**, which is judge-made law, developed through decided cases. **Acts** (also known as statutes) passed by the legislature are the second source of law. In Québec, at least in theory, all laws come from acts. However, judges who decide Québec civil law cases interpret the acts, and as a result shape what the law is.

Civil Liability and HIV Disclosure

Both the non-disclosure and the disclosure of HIV status may lead to findings of civil liability. Here are three possible situations where civil liability might arise:

- A **PHA could be sued** by a sexual or injection drug partner for having unprotected sex or sharing unclean injection drug equipment without disclosing his or her HIV status.
- A **counsellor or CBAO could be sued by the sexual or injection drug partner of a client** for not taking steps to prevent the client from exposing the partner to HIV.
- A **counsellor or CBAO could be sued by a client** for disclosing his or her HIV status without the client's consent.

THERE ARE NO CANADIAN COURT DECISIONS ABOUT THESE SITUATIONS. WE CANNOT SAY FOR CERTAIN WHETHER OR NOT A COURT WOULD FIND A PHA, COUNSELLOR OR CBAO CIVILLY LIABLE.

We analyze how a court **may** decide civil cases about HIV disclosure and non-disclosure.

Civil Liability of PHAs

Civil Liability of PHAs under Québec Law

Québec is the only civil law jurisdiction in Canada. In civil matters, it is governed by the Civil Code of Québec. The Civil Code governs persons, relations between persons, and property. The Civil Code is the foundation of all other laws enacted by the Québec legislature, although other laws may complement the Civil Code or make exceptions to it. The Civil Code establishes a **cause of action for civil liability**. Article 1457 of the Civil Code provides:

> Every person has a duty to abide by the **rules of conduct** which lie upon him, according to the circumstances, usage or law, so as **not to cause injury to another**. Where he is endowed with reason and **fails in this duty, he is responsible for any injury** he causes to another person by such fault and is liable to

> reparation for the injury, whether it be bodily, moral or material in nature. He is also liable, in certain cases, to reparation for injury caused to another by the act or fault of another person or by the act of things in his custody. [Emphasis added.]

This is the general civil liability provision in Québec. It would be the legal basis of a lawsuit against a PHA by a sexual or injection drug partner for not disclosing his or her HIV status before engaging in a high risk activity.

Cuerrier clearly sets out a **rule of conduct** for PHAs. They must disclose their status to sexual partners before engaging in unprotected sexual intercourse. It is also clear that PHAs have a legal duty not to share unclean injection drug equipment without disclosing their status. A PHA who had unprotected sexual intercourse or shared injection drug equipment would likely be civilly liable for any injury caused to a partner because of those activities.

Québec court judges will determine exactly what duties PHAs have under the civil law when engaging in lower risk sexual and injecting drug activities when they decide a case that raises those issues.

Civil Liability of PHAs in Other Provinces and Territories

In provinces other than Québec, and in the territories, a PHA may be liable in **tort** for having sexual intercourse without first disclosing his or her HIV status. A tort is a **civil wrong** (other than a breach of contract) that can be the basis of a lawsuit for monetary damages. If sexual and injecting-drug partners do bring civil court cases against people living with HIV, the partners will likely rely on the **tort of battery** and the **tort of negligence**.

Tort of Battery

Battery is the **intentional, unconsented touching of one person by another person**. The person need not cause any harm or even intend harm to the other person. Offensive contact is enough. **Consent is a defence against a charge of battery.** However, a person who has obtained consent by deception cannot rely on the defence of consent.

In the ***Cuerrier*** case, the Supreme Court decided that **lying or not telling a partner about one's HIV-positive status before engaging in unprotected sexual intercourse vitiates** (in other words, breaks) the partner's consent. Because not disclosing HIV status to a sexual partner vitiates consent under criminal law, it almost certainly would under civil liability law.

Tort of Negligence

In its legal sense, **negligence is a cause of action in tort**. Negligence protects the interest of anyone who is injured because another **person did not do something he or she had a legal duty to do, or did something he or she had a legal duty not to do**.

In order for a plaintiff to be successful in lawsuit based on the tort of negligence, he or she must **prove three elements**:

1. a **duty of care** exists between the plaintiff and the defendant;
2. the defendant **breached that duty**; and
3. the plaintiff suffered **foreseeable damage as a result** of the breach.

Although no Canadian court has decided the issue, it is very likely that a PHA owes a **duty of care** to his or her sexual or drug-injecting partner(s). The **content of the duty of care that is owed to another person is called the standard of care**. The standard of care depends on what the reasonable person would expect from the HIV-positive person in all circumstances of the case. In light of ***Cuerrier***, it is very likely that a court would say that the standard of care requires an HIV-positive person to disclose her or his HIV-positive status to a partner before engaging in activities that have a significant risk of HIV transmission. Because no court has decided the issue, it is not clear if the standard of care requires PHAs to disclose their HIV status before participating in low risk activities.

Finally, in an action in negligence the sexual or injecting drug partner would have to prove that he or she suffered **damage as a result of the non-disclosure by the PHA**. A court would almost certainly consider being infected with HIV a "damage". A plaintiff might also be successful

even if he or she were not infected. She may be able to show other damage, such as emotional and psychological harm, from being exposed to HIV with the chance of infection.

Civil Liability of Counsellors and CBAOs

Civil Liability of Counsellors and CBAOs under Québec Law

The Civil Code of Québec includes a right to respect for personal reputation and privacy. No one may invade the privacy of a person without the consent of the person in question unless authorized by law. The Québec Charter of Human Rights and Freedoms is similar to human rights codes or acts in other provinces and territories. However, it is different in a number of significant ways. One difference is that the Québec Charter protects privacy and confidentiality. Section 5 provides that "[e]very person has a right to respect for his private life", and section 9 provides that "[e]very person has a right to non-disclosure of confidential information".

A CBAO or counsellor has a duty to keep client information confidential under Québec civil law. Each also has a duty not to release this information except with the client's consent. However, as long as the decision to disclose and the steps taken to prevent harm were reasonable, a court might find that the counsellor or CBAO was not civilly liable for disclosing client information without consent. The court would look at the facts and circumstances of the case to decide whether the decision to breach confidentiality and disclose client information was **reasonable**.

The court would probably analyze the issue based on the **public safety exception** to confidentiality created by the Supreme Court in the ***Smith v Jones*** case. The public safety exception is reviewed in detail in Chapter 7 (Client Confidentiality and Record-Keeping), and briefly in the section below.

Civil Liability of Counsellors and CBAOs in Other Provinces and Territories

Counsellors and CBAOs have a duty to maintain client confidentiality. Where a counsellor receives confidential information from a client, the counsellor is under a legal duty not to use that information for any purpose other than counselling the client. If the information is used for another purpose, particularly if it is to the detriment of the client, the client is entitled to seek a remedy by bringing a lawsuit for breach of confidence.[1] To prove that there has been a breach of confidence, a client must establish three elements.[2] The client must prove that the information given to the counsellor or CBAO was:

1. **confidential**;
2. was **communicated in confidence**; and
3. was **misused by the counsellor or CBAO**.

There are **no reported Canadian cases of breach of confidence brought against a counsellor, psychiatrist, social worker, physician, other health care professional or hospital**.

A counsellor or CBAO who breaches client confidentiality may be faced with an action for breach of confidence. Whether or not a court would hold the counsellor or CBAO civilly liable for breach of confidence would likely depend upon what the counsellor told the client about the confidentiality of their information, and how the counsellor then used the information.

A client who reveals **personal information** to a counsellor is revealing **confidential information**. The client will have to prove that he or she **communicated the information in confidence**. Where the counsellor told the client about the **public safety exception** to the duty of confidentiality at the outset of the relationship, it would be more difficult for the client to prove that he or she communicated the information in confidence.

Even where a counsellor does not advise the client about the public safety exception, **the counsellor and CBAO may still have a defence to an action for breach of confidence**. A CBAO might be released from its duty to protect client confidentiality if it can prove the three elements of the public safety exception:

1. There is a clear risk of harm to an identifiable person or group of persons.

2. There is a significant risk of serious bodily harm or death.
3. There is imminent danger.

Remember, when these three conditions are met, the counsellor **may break client confidentiality**. Nevertheless, the counsellor has **no legal obligation to do so**. These three conditions would probably be met in the situation where a counsellor has a reasonable belief that:

- an HIV-positive client refuses to disclose his or her HIV status before having unprotected sexual intercourse or sharing unclean injection drug equipment;
- an HIV-positive client intends to continue having unprotected sexual intercourse and sharing unclean injection drug equipment; and
- the counsellor knows the identity of the client's sexual or injection drug partners.

The best way for a counsellor to protect him or herself and the CBAO from civil liability is to advise clients about the public safety exception, and to only disclose client information to prevent harm to a third party where the three conditions in the *Smith v Jones* test are met. But a court has not decided this issue, so there is no proven defence.

A Note on Civil Liability of Professionals and Professional Discipline

Counsellors who are professionals (like registered nurses, registered psychologists, registered social workers and physicians) can be sued for breaches of client confidentiality. Because trust and confidence are at the core of the relationship between a professional and a client, the law imposes a super duty (known as a fiduciary duty) on the professional to hold client information in confidence. This duty may make it harder for a professional to legally justify breaching client confidentiality.

A client can also file a complaint against a professional with the professional's regulatory body. Professional regulatory bodies do not have the power to award monetary damages to a patient. But regulatory bodies do have the power to discipline health care professionals for incompetence or misconduct, and can impose sanctions such as revoking, suspending or placing conditions on the professional's licence to practice, reprimanding the professional, or imposing a fine.

The Defensive Role of Policy

Part of the role of a CBAO board is to develop policies and guidelines to help staff and volunteers fulfil the organization's mandate, and to help limit the organization's civil liability. From a civil liability standpoint, it is a good idea for a CBAO to have a confidentiality and record-keeping policy and to follow it.

Courts place great weight on the particular facts of each case, including the parties' actions. Courts are more likely to find in favour of a party who acted reasonably. It is reasonable for a CBAO to adopt confidentiality and record-keeping policy firmly grounded legal and ethical duties. It is reasonable for counsellors to follow the CBAO's confidentiality and record-keeping policy. Where CBAOs have a sound policy, which its counsellors follow, a court will be less likely to impose civil liability on either the CBAO or the counsellor.

[1] *LAC Minerals Ltd. v International Corona Resources Ltd.*, [1989] 2 SCR 574.

[2] *LAC Minerals Ltd. v International Corona Resources Ltd.*

Disclosure of HIV Status After *Cuerrier*

Appendix A

Briefing Note for CBAOs

Canadian AIDS Society / Société canadienne du sida

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

BRIEFING NOTE FOR CBAOs

HIV Disclosure and the Criminal Law in Canada: Responding to the Media and the Public

Purpose

The purpose of this Briefing Note is to give community-based AIDS organizations (CBAOs) information to help them respond to media questions and other inquiries. The information in this Briefing Note is intended to provide responses that are positive and constructive, and respect people living with HIV.

The information contained in this Briefing Note is "brief". It is intended to provide you with short "sound bites" so you can **effectively communicate your important message**.

What information does the Briefing Note contain?

This Briefing Note is organized into three parts:

1. Why a response is needed
2. Suggestions on how to respond
3. Essential facts about criminal law and HIV disclosure

The Briefing Note does not provide concrete and definitive answers to all of the questions or issues you may be asked to answer or respond to. This is because the criminal law about HIV disclosure is complex and sometimes unclear.

For more information …

For people who want more information and to develop a deeper understanding of all of the issues involved, you can read:

- **The eight info sheets on Criminal Law and HIV** [Canadian AIDS Society and Canadian HIV AIDS Legal Network]. The law in these info sheets was updated in 1999. Since that time, the Supreme Court has released its judgment in ***R v Williams*** and there have been a number of other court decisions. The important court decisions are mentioned in this Briefing Note. The info sheets are available at: www.aidslaw.ca/Maincontent/infosheets.htm

- ***After Cuerrier: Canadian Criminal Law and the Non-Disclosure of HIV-Positive Status*** [Canadian HIV/AIDS Legal Network, 1999], available at: www.aidslaw.ca/Maincontent/issues/criminallaw/finalreports/cuerrier/tofc.htm
- ***Note on R v Williams (criminal liability for HIV exposure)***, 18 September 2003 [Canadian HIV/AIDS Legal Network], available at: www.aidslaw.ca/Maincontent/issues/criminallaw/williams-comment.htm
- ***HIV Transmission: Guidelines for Assessing Risk* (3rd edition, 1999)** [Canadian AIDS Society]. A 4th edition of the *Transmission Guidelines* is going to be published in the spring of 2004. The *Transmission Guidelines* are available from the Canadian AIDS Information Centre: www.aidssida.cpha.ca

This Briefing Note was prepared and distributed by the Canadian HIV/AIDS Legal Network, in partnership with the Canadian AIDS Society. If you have questions about the Briefing Note or want to give us your feedback, please contact:

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Why a response is needed

Some members of the Canadian AIDS Society and the Canadian HIV/AIDS Legal Network asked for tools to help them respond to media questions and public perceptions about HIV disclosure and criminal law.

Media often sensationalize stories about people living with HIV/AIDS who are charged or found guilty of Criminal Code offences related to HIV transmission. They often present the issue of people who are unwilling or unable to disclose their HIV status out of context or do not fully take into account the realities of people living with HIV/AIDS. This affects how the public views people living with HIV. It contributes to a climate of fear and stigmatization of people living with HIV, and discrimination against people living with HIV.

Community-based AIDS organizations are approached by the media to comment on cases where Criminal Code charges have been laid. Community-based AIDS organizations should be prepared to counter the negative messages in the media by providing accurate information about the law and the context of HIV disclosure for people living with HIV. Community based AIDS organizations may also want to use this Briefing Note as a basis to engage people in their local communities, or as a **starting point** for counselling clients.

Suggestions on how to respond

Key messages

Here a few key messages about HIV disclosure and criminal law that the Canadian AIDS Society and the Canadian HIV/AIDS Legal Network believe are important:

1. **Studies show that most people living with HIV tell their sexual partners about their HIV status and take steps to prevent HIV transmission (like using condoms during sexual intercourse).** Criminal law cases, like all court cases, are brought when things have gone wrong. We need to remember this fact. Cases like *Cuerrier/Williams/* the case you are speaking about are rare and certainly do not indicate the way most people living with HIV behave in their sexual relationships.
2. **It is unfair to stigmatize all people living with HIV because of the conduct of a few individuals.** People living with HIV already face fear, stigma and discrimination. People living with HIV do not deserve to be treated as criminals simply because they are HIV-positive.
3. **Everyone, not only people who know they are HIV-positive, has a responsibility to stop HIV transmission.** HIV is a reality in Canada. There are approximately 50,000 people living with HIV in Canada — but 30% do not know that they are infected and so they can't tell their partners. So whenever and wherever possible, people should take personal responsibility by using condoms when engaging in sexual intercourse.
4. **Some people living with HIV may not be able to disclose their HIV status to their sexual partners because they fear for their safety.** HIV-positive people in abusive relationships may not be able to use a condom or insist that their partner use a condom. They may also fear the consequences of disclosing their HIV status to their partner.
5. **Relying too heavily on the criminal law to prevent HIV transmission may be counterproductive.** It is unlikely that the threat of criminal penalties will stop people from having risky sex or sharing injection equipment (needles and syringes).
   - Instead, criminal penalties will deter those most at risk from getting tested for HIV. And if someone does not get tested, they will not receive counselling about changing behaviours that risk HIV transmission. Nor will they find out if they are HIV-positive, or access medical treatment and support services.
   - Criminalizing high risk sexual and drug injecting behaviours further stigmatizes people living with HIV and makes it even more difficult to provide effective education about preventing HIV infection (especially for socially marginalized communities most at risk).
   - Finally, threatening people who expose someone else to HIV with criminal prosecution may create a false sense of security among HIV-negative people.

6. **People living with HIV are entitled to a healthy sex life, just like everyone else.** People living with HIV do not have to tell every sexual partner that they are infected with HIV. According to the Supreme Court's *Cuerrier* decision, HIV-positive people have a legal duty to disclose their status before they have sex that places the other person at a significant risk of serious bodily harm — in other words, at significant risk of HIV infection. Not all sexual activities carry a significant risk of HIV infection [for example, kissing and oral sex]. And in the *Cuerrier* decision, the Supreme Court suggested that HIV-positive people might not have a duty to tell partners they are HIV-positive if they use condoms for sexual intercourse. But the courts have not confirmed this suggestion, so it is not the law.
7. **The *Williams* case goes too far by suggesting that people who think there is a risk they may be HIV-positive have a legal duty to tell others.** It is not a good idea to "extend" the criminal law (and its serious penalties) beyond cases where someone knows for certain that he or she is HIV-positive, based on a medical test or diagnosis. Many sexually active people in Canada have had unprotected sexual intercourse — an activity that carries a high risk of HIV infection. Remember, 30% of HIV-positive people in Canada do not know they are infected. And you can't tell just by looking at someone whether or not he or she is HIV-positive. So do all of these people who have had sexual intercourse without a condom have a legal duty to tell their sexual partners that they may be HIV-positive? The criminal law and criminal investigations should not police the most intimate details of people's sexual lives and sexual histories based only on a risk that someone may be HIV-positive.

Tips on how to answer questions

Journalists' and reporters' questions may not be based on a good understanding of the legal and medical issues involved in HIV disclosure and HIV transmission. They may not be aware of the reality of people living with HIV. You probably have a better understanding of the issues, and almost certainly a better understanding of the perspective of people living with HIV. This is part of the reason that journalists and reporters are asking you for information, answers and comments.

So, while it is important to try to answer journalists' and reporters' questions, it is more important to get your point across. **Think of each question as an opportunity to make your point and to be an advocate for your clients and other people living with HIV.**

When the journalist or reporter first contacts you, it is a good idea to ask what types of questions she will be asking you. **It is also perfectly OK (not to mention a good idea) to ask the journalist or reporter to call back later to do the actual interview.** This will give you time to look over the Briefing Note and any other information you need to. You will have a chance to think about and formulate your answers and remind yourself of the key messages or points you want to make in the interview.

Essential facts about criminal law and HIV disclosure

People living with HIV have a legal duty to disclose …

As a result of the *Cuerrier* decision of the Supreme Court of Canada, people living with HIV have a legal duty to disclose their HIV status before engaging in behaviours that put another person at **significant risk of serious bodily harm**. The Court clearly stated that risk of HIV infection is risk of a serious bodily harm.

An HIV-positive person does not have to infect the other person with HIV to be criminally charged. It is enough that they put the other person at a significant risk of HIV infection.

The two most common situations where there is a significant risk of HIV transmission are: (1) **unprotected sexual intercourse** (anal or vaginal); or (2) **sharing injecting equipment** (needles and syringes) that contains HIV-infected blood.

Practically speaking, this means that people living with HIV must disclose their HIV status before having unprotected intercourse (vaginal or anal) and before sharing injecting equipment (needles and syringes) that contains HIV-infected blood.

In the *Cuerrier* case, the Supreme Court **suggested that careful use of a condom may reduce the risk of HIV transmission** to the point where the risk of serious bodily harm is not significant. And as a result, an HIV-positive person who properly uses a condom **might not have a legal duty to disclose** his or her HIV status before engaging in sexual intercourse. But this was **only a suggestion** by the Supreme Court, and it **not the law**.

Whether or not a person living with HIV has a legal duty to disclose their HIV status before sex (or sharing injection drug equipment) **will depend upon the risk of HIV transmission** associated with the sexual (or drug injecting) activity.

People living with HIV **do not have to disclose their HIV status** to sexual partners before engaging in activities that pose **no risk or negligible risk of HIV transmission**. [kissing; cuddling; mutual masturbation; digital-anal intercourse, insertive or receptive fellatio/ cunnilingus with a condom.]

It is **unclear** whether or not people living with HIV have a legal duty to disclose their HIV status to sexual partners before engaging in activities that pose **low risk of HIV transmission** [oral sex without a condom; intercourse with a condom]. In *R v Edwards*, a lower court judge indicated that there is no legal duty to disclose HIV status before unprotected oral sex because it is a low risk activity.

In the *Williams* case, the Supreme Court of Canada opened up the possibility that a person who is **aware of the risk that he or she has contracted HIV** may have a legal duty to tell his or her sex partner about this before engaging in unprotected sexual intercourse. So a person who thinks he or she may be HIV-positive, **even if he or she does not know for sure**, may have a duty to tell sexual and injection drug use partners before engaging in high-risk behaviour.

The Supreme Court in the *Williams* decision also left the door open for people living with HIV to be held **criminally liable for engaging in activities that would put an HIV-positive person at risk of re-infection with HIV**. Depending on the medical and scientific evidence, it may be possible to prove that re-infection with a different or drug-resistant strain of HIV can result in a serious bodily harm that would endanger the life of someone who was already HIV-positive. So even if people living with HIV know that their sexual or drug injecting partner is HIV-positive, they may have a legal obligation to disclose their HIV status to that person when engaging in activities that have a significant risk of HIV transmission. But a court has not definitively decided this issue.

What Criminal Code charges do people living with HIV face if they breach the legal duty to disclose?

People who are charged under the Criminal Code for putting others at risk of HIV infection are likely to be charged with either **aggravated assault** or **common nuisance**, or **both**.

Under the Criminal Code, a person commits an **assault** when he or she applies force intentionally to another person without the other person's consent. Force means touching. The person's consent to the touching (or sex) is not valid if it is obtained by fraud. Fraud means either lying or not telling. The maximum term of imprisonment for assault is 5 years.

Under the Criminal Code an assault becomes an **aggravated assault** where a person commits an assault that endangers the life of another. The maximum term of imprisonment for aggravated assault is 14 years. In the ***Cuerrier*** case, the Supreme Court decided that an HIV-positive person who has unprotected sexual intercourse without disclosing his HIV status is guilty of aggravated assault because of the risk of infection with HIV, which endangers the other person's life.

In the ***Williams*** decision, the Supreme Court was faced with a situation where an HIV-positive person had unprotected sexual intercourse with someone who was likely HIV-positive. The Court decided that where there is a reasonable doubt whether or not the other person was HIV-positive before the unprotected sexual intercourse, the person's life may not have been endangered. So the HIV-positive person cannot be found guilty of the Criminal Code offence of aggravated assault. But he or she would be guilty of **attempted aggravated assault**. The maximum term of imprisonment for attempted aggravated assault is 7 years.

Under the Criminal Code, a person is guilty of **common nuisance** if he or she fails to discharge a **legal duty** and as a result **endangers the lives, safety or health** of the public. People living with HIV have a legal duty to disclose their HIV status before engaging in any activity that carries a significant risk of HIV transmission. People living with HIV have been convicted of common nuisance for having unprotected sexual intercourse without first telling their sexual partner that they were HIV-positive. The maximum term of imprisonment for common nuisance is 2 years.

Legal duties of community-based AIDS organizations

CBAO staff and volunteers have a legal **duty to keep client information confidential**. This means that, **as a general rule**, client information **cannot be released or disclosed without client consent**.

CBAO staff and volunteers **may be forced to disclose client information** to police under a **search warrant**, or to a court where a judge orders someone to attend court and give evidence (known as a **subpoena**).

- CBAOs faced with a police search warrant to seize client information can "assert privilege" over the information. To do this, the CBAO must place client information in a sealed envelope, and write PRIVILEGE ASSERTED — DO NOT OPEN on the envelope before giving it to police. The CBAO or the client can then ask a court to decide whether the police can legally use the information. The CBAO should get legal advice, and advise their client to do so, as soon as possible.

CBAO staff and volunteers do **NOT have a duty under the Criminal law to report to police clients** who engage in sex or injecting activities that risk HIV transmission. Therefore, CBAOs cannot be charged with or convicted of a criminal offence for failing to report a client to police.

Employees of CBAOs who are members of a professional body (like registered nurses and social workers) **may have an ethical duty to disclose client information** to prevent harm where a client's behaviour places a known person at risk of HIV infection.

CBAOs, their staff and their volunteers **may be sued in civil court by a client** and found civilly liable if they disclose client information without consent, or without being compelled to do so under a search warrant or court order.

CBAOs, their staff and their volunteers **who do not take steps to prevent harm to a third party may be sued in civil court by anyone who suffers harm as a result of the failure to take those steps**. But since no Canadian court has decided this issue, **it is not clear** whether the third party would win or lose the case.