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## Equality Rights for People with AIDS: Mandatory Reporting of HIV Infection and Contact Tracing

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This paper focusses on one critical aspect of the AIDS epidemic where the American response has demonstrated a greater sensitivity to the stigma attached to AIDS and to the privacy interest of the individual: anonymous HIV antibody testing and contact tracing. Using the paradigmatic examples of the approaches in Ontario and New York, the author concludes, through an analysis using section 15 of the *Charter*, that the American approach of anonymous HIV antibody testing and physician-centred contact tracing is both a more sensitive and constitutionally legitimate response to the AIDS epidemic.

Cet article traite de l'administration anonyme des tests de séropositivité et du dépistage des réseaux de contacts. Il montre comment les États-Unis ont démontré une plus grande sensibilité au droit à la vie privée des individus et aux stigmates qui sont attachés aux SIDA. L'auteur utilise comme paradigmes les approches de l'Ontario et de New-York. Après une analyse basée sur l'article 15 de la *Charte*, il conclut que les pratiques américaines d'anonymité des tests et de dépistage par les médecins des réseaux de contacts constituent une réaction à la fois plus humaine et, au plan constitutionnel, plus légitime.

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## Introduction

AIDS has become a focal point for the acute social tensions that have long surrounded issues of disease, sex, and class. These profound fault lines of contemporary society have converged on the AIDS crisis and deeply influenced our understanding of and response to AIDS. Yet it is times of adversity that test our capacity for justice and compassion. How we respond to this complex social crisis will not only determine the course of this epidemic, but will as well reveal much about our ability to address these broader social tensions.

As the AIDS epidemic has gained greater force over the seven years since the disease was first identified,<sup>1</sup> it can be said with fairness that to date the response of Canadian lawmakers and health professionals has been moderate and informed. In particular, although Canada faces an epidemic in many ways as severe as that in the United States,<sup>2</sup> Canada's response has generally been to avoid many of the dramatic and questionable examples of American policy regarding AIDS. For example, to date the Government of Canada has refrained from following the American precedent of initiating

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<sup>1</sup>AIDS was first identified in 1982 by the Centers for Disease Control in Atlanta, Georgia. See Institute of Medicine—National Academy of Sciences, *Confronting AIDS: Directions for Public Health, Health Care, and Research* (Washington, D.C.: National Academy Press, 1986) at 37 [hereinafter *Confronting AIDS*].

<sup>2</sup>Although the number of AIDS cases in Canada is proportionally lower than in the United States (the rate for 1,000,000 is 69.8 in Canada and 263.1 in the United States), the spread of the disease in Canada has been devastating and rapid. As of 23 January 1989, a total number of 2,337 cases of AIDS had been reported to the Canadian Federal Centre for AIDS, over half of whom have died. It is estimated that as of September 1987 about 30,000 Canadians were infected with the Human Immunodeficiency Virus ("HIV"), the generally accepted cause of AIDS. Within the group between 20-49 years of age, AIDS has become the fourth leading cause of death in Canada. By 1992, AIDS could become the leading cause of death within this age group. See Royal Society of Canada, *AIDS: A Perspective for Canadians—Summary Report and Recommendations*, vol. 1 (Ottawa: Royal Society of Canada, 1988) [hereinafter *AIDS: A Perspective for Canadians*] and Federal Centre for AIDS, *Report for 1988* (Ottawa: Supply & Services Canada, 1989) at 30.

As of 4 July 1988, a total of 66,464 AIDS patients had been reported in the United States, over half of whom have died. Between one and 1.5 million Americans are infected with HIV. By 1992, an estimated 365,000 Americans will have developed AIDS. See W. Heyward & J. Curran, "The Epidemiology of AIDS in the U.S." (1988) 259:4 *Scientific American* 72.

mandatory Human Immunodeficiency Virus ("HIV") antibody testing<sup>3</sup> of military personnel,<sup>4</sup> state department officials,<sup>5</sup> and applicants for permanent residency status.<sup>6</sup> The provincial governments have also chosen not to follow the example set by the cities of New York and San Francisco, both of which have closed local gay bathhouses.<sup>7</sup> Most importantly, Canada's national health care system spares Canadians one of the most pressing and

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<sup>3</sup>The evidence is now "scientifically conclusive" that HIV is the cause of AIDS, even though the pathogenesis of HIV infection (how the organism causes disease) is still incompletely understood. AIDS is primarily a disease of the body's immune system. Individuals infected with HIV exhibit a progressive immunologic compromise which leaves the body highly susceptible to life threatening opportunistic infections. Blood tests have been developed which can detect the presence of HIV antibodies; all individuals who carry HIV antibodies (*i.e.* their blood tests seropositive for the HIV antibody) are assumed to be infected with HIV and, for practical purposes, capable of transmitting the virus. See generally, *Confronting AIDS, supra*, note 1 at 37-49, and Institute of Medicine—National Academy of Sciences, *Confronting AIDS: Update 1988* (Washington, D.C.: National Academy Press, 1988) at 33-35 [hereinafter *Confronting AIDS: Update 1988*].

Until recently, it was believed that not all HIV infected individuals would develop AIDS, however new evidence indicates that the great majority of HIV infected persons will eventually progress to AIDS in the absence of effective therapy to slow or halt the infection's progression. It is estimated that as many as 100 per cent of HIV infected persons will develop AIDS within 13 years after initial infection [*Confronting AIDS: Update 1988* at 35-36]. Other studies have found that the average incubation period, the time from infection to the development of AIDS, is between seven to eight years, and anywhere from 30 to 75 per cent of individuals will progress to AIDS within six years. A San Francisco study found that only 20 per cent of HIV-infected people remained completely asymptomatic after seven years and two months of infection: "It is increasingly being recognized that this percentage [of people who progress to AIDS] may be essentially 100 per cent, with the only uncertainty being the distribution of time to the development of disease." See generally R.M. May, R.M. Anderson & S.M. Blower, "The Epidemiology and Transmission Dynamics of HIV-AIDS" (1989) 118:2 *Dædalus* 163 at 169.

Although there is no known cure for AIDS, some treatments for HIV infection are now available, notably azidothymidine ("AZT") which has proven effective in slowing the development of the disease. Numerous drug trials are presently underway testing possible AIDS therapies. See R. Yarchoan, H. Mitsuya, & S. Broder, "AIDS Therapies" (1988) 259:4 *Scientific American* 110.

Before the progressive nature of HIV infection was well understood, researchers commonly believed that "full-blown AIDS", "AIDS-related complex" ("ARC"), and "asymptomatic HIV infection" were distinct medical conditions. It is now evident that HIV infection is a "continuum of conditions ranging from the acute, transient mononucleosis-like syndrome associated with seroconversion, to asymptomatic HIV infection, to symptomatic HIV infection, and finally, to AIDS, a spectrum that encompasses a great variety of clinical symptomatology." [*Confronting AIDS: Update 1988, ibid.*, at 37]. In the opinion of Institute of Medicine of the Academy of Sciences in Washington D.C. and the Atlanta Centers for Disease Control, the previous distinction made between AIDS and ARC "is no longer useful, either from a clinical or a public health perspective, and that HIV infection itself should be considered a disease" [*ibid.* at 37]. Because a majority of HIV-infected individuals show some evidence of progressive immunodeficiency, it is now clear that AIDS is only "end-stage HIV infection" [*ibid.*] and many researchers now speak of "HIV disease" as an umbrella term to describe the progression from HIV infection to AIDS. In this paper the term "HIV disease" is used to describe the

tragic aspects of the AIDS epidemic in the United States — the lack of adequate and humane medical care for people with AIDS.<sup>8</sup> Given the profoundly different responses to the AIDS epidemic in the two countries, a divergence which may reveal something about the elusive yet distinctive Canadian political and social compact, it can be asked whether Canada has only to learn from the excesses of its neighbour to the south or whether

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entire continuum of conditions produced by HIV infection.

Viewing all HIV infection as a disease is important because it may eventually be amenable to early treatment [*ibid.*]. The evolving concept of HIV disease also has critical legal and public health ramifications as it becomes more evident that all HIV infection (including asymptomatic infection) constitutes a physical disability (as argued below in Part III). Both for the purposes of treatment and public health, rather than basing our understanding of AIDS on “arbitrary definitions of when ‘disease’ begins”, all HIV infection should be considered a disease. [*Confronting AIDS: Update 1988, ibid.*, at 38]. See also G.H. Friedland, “Clinical Care in AIDS Epidemic” (1989) 118:2 *Dædalus* 59 at 65 where the author states: “It is essential to view HIV infection as a chronic viral illness progressing inexorably over time.”

HIV disease, although infectious, is not highly contagious or easily transmitted. HIV infection is primarily spread in only three ways: transfusion of blood (the screening of blood donations has virtually eliminated this route of transmission), intravenous drug use (the sharing of unsterilized needles), and sexual transmission (both homosexual and heterosexual sexual activity may transmit the virus — the use of condoms significantly reduces the risk of transmission). There is no evidence that health care workers or family members caring for AIDS patients are at any increased risk of HIV infection. See generally G. Friedland & R. Klein, “Transmission of the Human Immunodeficiency Virus” (1987) 317 *New Eng. J. Med.* 1125.

<sup>4</sup>All recruits to the American military are currently required to submit to an HIV antibody test and those who test positive are ineligible for military service. See A.R. Rubinfeld, ed., *AIDS Legal Guide* 10-1 to 10-6 (2d ed. 1987).

According to Major-General R.W. Fassold, the Canadian Surgeon-General, the Canadian military does not engage in HIV screening for recruits. Condoms have also always been available free of charge to military personnel, both for the prevention of venereal disease and the transmission of HIV. See “How our military deals with AIDS” *The Toronto Star* (3 May 1987) B5. See also Canadian Bar Association — Ontario, “Report of the Canadian Bar Association — Ontario Committee to Study the Legal Implications of Acquired Immunodeficiency Syndrome (AIDS)” (Toronto: The Association, 25 April 1986) (Chair: T. Tremayne-Lloyd) at 30-31 [hereinafter *CBA Report*]. The Report did not recommend the introduction of HIV screening in the military.

<sup>5</sup>In *Local 1812, Am. Fed'n of Gov't Employees v. United States Dep't of State*, 662 F. Supp. 50 (D.C. Cir. 1987), the Court denied a motion for a preliminary injunction to prevent the United States Department of State from screening employees and prospective employees for HIV infection. The Department's primary justification was to protect employee health by preventing infected individuals from being posted to parts of the world with inadequate medical facilities.

<sup>6</sup>All aliens who apply for permanent residence in the United States are required to undergo an HIV antibody test and those who test positive are denied permanent residence status. See Rubinfeld, ed., *AIDS Legal Guide, supra*, note 4, 11-3 to 11-4.

Although the Canadian federal government has considered implementing mandatory HIV tests for applicants for permanent residency [“Government Strongly Considering Testing of All Immigrants for AIDS”, *The [Toronto] Globe and Mail*, (7 November 1987) A1], and the *CBA Report, supra*, note 4 at 37-9 recommended the implementation of such tests, the federal

more profound insights can be derived from the American experience with, and reaction to, AIDS.

This paper focusses on one critical aspect of the AIDS epidemic where the American response has demonstrated a greater sensitivity to the stigma attached to AIDS and to the privacy interest of the individual: anonymous

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government to date has refrained from doing so. Although the federal government does not require mandatory tests, if an HIV infected applicant offers information of his HIV status, he will be considered inadmissible for the purposes of s. 19(1) of the *Immigration Act, 1976 S.C. 1976-77, c. 52*. See T. Ducharme, "Preparing for a Legal Epidemic: An AIDS Primer for Lawyers and Policy Makers" (1988) 26 *Alta. L. Rev.* 471 at 481.

The World Health Organization of the United Nations strongly opposes HIV-related restrictions on international travel and immigration, noting that this will do little to reduce the spread of HIV. As Dr. Mann, WHO Director of the Special Programme on AIDS noted in his address to the World Summit of Ministers of Health on Programmes for AIDS Prevention (26-28 January 1988), "[u]nfortunately, as anxiety and fear cause some to blame others, AIDS has unveiled thinly disguised prejudices about race, religion, social class, sex and nationality. As a result, AIDS now threatens free travel between countries and open international communication and exchange."

<sup>7</sup>See J. Rabin, "The AIDS Epidemic and Gay Bathhouses: A Constitutional Analysis" (1986) 10 *J. of Health Politics, Policy and Law* 729, and S. Collier, "Preventing the Spread of AIDS by Restricting Sexual Conduct in Gay Bathhouses: A Constitutional Analysis" (1985) 15 *Golden Gate U.L. Rev.* 301.

In *City of New York v. New Saint Mark's Baths*, 130 Misc. 2d 911, 497 N.Y.S. 2d 979 (Sup. Ct. 1986), and *State of Georgia ex rel Slaton v. Fleck & Assocs.*, 622 F. Supp. 256 (D. Ga. 1985), bathhouses allegedly "used predominately as a meeting place for males and . . . continuing and frequent incidents of lewdness, oral and anal sodomy, and sexual contact between various male patrons. . . ." [*Slaton, ibid.* at 257], were closed for the asserted purpose of reducing the spread of AIDS. See also Dr M.F. Silverman, "Introduction: What We have Learned", in *What to Do About AIDS: Physicians and Mental Health Professionals Discuss the Issues*, L. McKusick ed., (Berkeley: University of California Press, 1986) 1 where Dr. Silverman, former director of the San Francisco Department of Public Health, discusses the reasons for his decision in 1984 to close the gay bath houses in San Francisco, describing them as "an environment that encourages and facilitates multiple unsafe contacts, which are an important factor in the spread of this deadly disease" [at 7].

Closing bathhouses may not result in any decrease of unsafe sexual activity; only the locale will probably change. Further, closing bathhouses may eliminate the important educational role that bathhouses can serve in encouraging their patrons to practice safer sex.

<sup>8</sup>Although some states ban HIV testing by health insurance companies, in the United States most private health insurance companies require an HIV test for all applicants. Those who test positive are denied insurance. Health insurance is often provided as a job benefit to all employees without any screening tests, however people with AIDS often lose their jobs or are unable to continue working and as a result lose their health insurance coverage.

People with HIV disease who are without private health insurance often encounter a hostile and inefficient public benefits system. Although they may be eligible for Medicaid, applications for assistance can take as long as three years to be processed, Medicaid coverage often excludes experimental AIDS treatments, and public hospitals are generally inferior to private hospitals. See generally, J. Perkins and R.T. Boyle, "AIDS and Poverty: Dual Barriers to Health Care" (1986) 19 *Clearinghouse Rev.* 1283 at 1287-90; "Health Benefits: How the System Is Responding to AIDS" (1988) 22 *Clearinghouse Rev.* 724; and Rubinfeld, ed., *AIDS Legal Guide, supra*,

HIV antibody testing. Anonymous tests are generally available throughout the United States, thereby ensuring that the test results will remain confidential and that people will not be discouraged from determining their HIV antibody status for fear of possible disclosure.

Encouraging individuals to determine voluntarily their HIV antibody status is a vital factor in reducing the spread of infection, and this objective is seriously impaired if confidentiality is not guaranteed. Because most people at risk for HIV infection are either gay or intravenous ("IV") drug users, unless they can be assured that the results of HIV tests will remain confidential, they will be reluctant to determine their HIV status. Not only is there a legitimate fear that this information could be used to identify them as members of a vulnerable and unpopular sub-group, but there is also the fear that the information could be used to discriminate against them because they are likely carriers of an infectious and as yet incurable disease.<sup>9</sup> Anonymous testing is not only the best way to ensure confidentiality, it may be the only way to guarantee confidentiality in a complex system of modern health care where patients often lack any significant control over disclosure of their medical records.

In addition to the wide-spread availability of anonymous testing in the United States, contact tracing, a means by which public health officials seek to identify and locate susceptible contacts of an individual known to be infected with a communicable disease, has not been the central focus of American efforts to prevent and control the spread of HIV infection. Most states have concluded that aggressive, comprehensive state-supervised contact tracing for HIV infection would operate as a powerful disincentive to the early testing and detection of infectivity, thereby actually increasing the risk of the spread of HIV infection rather than containing it. Instead, public

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note 4, "Public Benefits" 6-1 to 6-4. See also W. Mariner, "Access to Health Care and Equal Protection of the Law: The Need for a New Heightened Scrutiny" (1986) 12 Am. J. of Law and Medicine 345, and L. Ozenberger, "Medical Indigency and Economic Scarcity: Are Egalitarian Access to Care and Cost Control Mutually Inconsistent Goals?" (1987) 33 Loy. L. Rev. 113.

As in the United States, HIV screening is, however, routinely done for applicants for life insurance in Canada and those testing positive are denied life insurance. See "AIDS test required by insurance firms for large policies" *The [Toronto] Globe and Mail* (13 November 1987) A1-A2.

<sup>9</sup>The reports of AIDS-related discrimination are too numerous to provide a detailed account here. Ron Lentz, a nurse at the Toronto Western Hospital was fired once it was discovered he suffered from AIDS. ["Nurse with AIDS irks job recruiters" *The [Toronto] Globe and Mail* [29 January 1988) A12.] Eric Smith, a teacher in Nova Scotia, was barred from the classroom when an employee in his doctor's office disclosed his HIV status. ["Exposed: revelation of AIDS connection leaves a Nova Scotia teacher in limbo" *The [Toronto] Globe and Mail* (3 October 1987) D2.] See generally, T. Ducharme, "Preparing for a Legal Epidemic: An AIDS Primer for Lawyers and Policy Makers", *supra*, note 6 at 484.

health authorities in the United States have largely reached a consensus that a less invasive form of contact tracing more effectively fulfills the imperative of public health: seropositive individuals are usually encouraged to perform contact tracing themselves or with the aid of their physician.

Contact tracing is thus not usually performed by state public health officials, and no state records of seropositive individuals are maintained. It is believed that this less invasive procedure fulfills the need to inform contacts who may not know they are at risk and, at the same time, ensures the confidentiality of HIV antibody test results.

This situation contrasts sharply with the general practice in Canada where in many provinces anonymous HIV testing is prohibited by law. In the most extreme case, the Ontario *Health Promotion and Protection Act, 1983*<sup>10</sup> requires that the results of all positive HIV tests be reported to the provincial Chief Medical Officer of Health with both the name of the individual infected and his or her "risk group" category, that is, whether the reported person has engaged in sex with a "high risk person" (homosexual or IV drug user) or is an IV drug user. The government thus maintains records of seropositive individuals, indicating those who are homosexual or IV drug users. If health care providers fail to report all findings of HIV seropositivity to the government, they are liable for prosecution under the Act.

At the same time, health care providers in Ontario are prohibited from disclosing the HIV status of their patient without the latter's consent to anyone other than the Medical Officer of Health, even if they believe that their patient presents a significant risk of infection to a contact. Only the provincial public health officer may proceed with contact tracing in the absence of the patient's consent.

Although notifying individuals who are unaware that they may be at risk for HIV infection is closely related to the public health objective of preventing the spread of HIV, a state-supervised contact tracing program is both the least effective and most intrusive means to achieve this objective. The violation done to patient confidentiality by requiring the mandatory reporting of HIV infection to the government only serves to discourage individuals from determining their HIV status, thereby increasing the risk of inadvertent HIV transmission. The objective behind contact tracing can still be achieved, and a greater degree of patient confidentiality can be ensured, if the physician is given the primary responsibility to inform contacts. Ontario, unique among the Canadian provinces in this regard, has chosen

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<sup>10</sup>S.O. 1983, c. 10, as. am. S.O. 1984 c. 55, s.227; and S.O. 1987, c. 18 and c. 32 [hereinafter *Health Promotion and Protection Act*].

a far more invasive and ultimately less effective means to reduce the spread of HIV infection.<sup>11</sup>

In order to understand the importance of anonymous HIV testing and the threat to public health posed by an aggressive, comprehensive, state-supervised contact tracing program for HIV infection, it is first necessary to investigate the stigma and moral meaning that has been ascribed to AIDS in our imagination, a subject addressed in Part I. Preventing the spread of HIV infection requires a sensitive and informed understanding of the complex social response to disease and contagion; only then can effective preventive measures be designed. This paper will then proceed in Part II with an examination of the present practice regarding the mandatory reporting of HIV infection and contact tracing in Ontario, which has the most actively enforced HIV contact tracing program in Canada. Part III will consider the public health ramifications and constitutional implications of this policy. Whether seropositive individuals are a protected class under either the American or Canadian *Constitution* will be considered, and, in particular, the argument will be made that HIV infection constitutes a physical disability under s. 15 of the *Charter of Rights and Freedoms*.<sup>12</sup> The paper will then conclude with a s. 1 analysis of a reporting and contact tracing program, and present the argument that such a program does not further the legitimate

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<sup>11</sup>A HIV mandatory reporting and contact tracing program very similar to the Ontario program was recently the subject of Proposition 102, a 1988 referendum sponsored by Congressman William Dannemeyer of California and rejected by California voters. The proposal would have required California physicians to report all findings of HIV infection with identifiers, and health officials were to be responsible for an aggressive and comprehensive contact tracing program. Anonymous HIV testing would have become illegal.

Proposition 102 was widely criticized by the medical establishment which has long feared that mandatory reporting and contact tracing could deter voluntary HIV testing. Frank Young, Commissioner of the Federal Drug Administration, called Proposition 102 a "terrible thing". Dannemeyer, its sponsor, charged that "opponents of this measure, supposedly the medical community, have gone out of their way to link arms with left-wing ideologues at the American Civil Liberties Union, the National Gay Rights Advocates and, inevitably, the University of California at Berkeley." See "California's Anti-AIDS Quackery" *The New York Times* (5 October 1988) I:33, and W. Dannemeyer, Letter to the Editor, *The New York Times* (31 October 1988) I:18.

The Ontario program, rather than a measured and responsible response to the threat of AIDS, is in fact in the company of the Dannemeyer Proposition 102, which in turn was inspired by the earlier Lyndon LaRouche Proposition 64, defeated in 1986, which would have required quarantine for the 250,000 Californians infected with HIV.

<sup>12</sup>*Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B of the *Canada Act 1982* (U.K.), 1982, c. 11. [hereinafter *Charter*]

public health objective of preventing the spread of HIV and is an unacceptable violation of equality rights of people with HIV disease.<sup>13</sup>

### I. Stigma, Metaphor, and Moral Meaning — What Does AIDS Signify?

Now, more than ever, we need to understand clearly and precisely what forces and values are mobilizing in relation to the ongoing crisis of AIDS. For AIDS is not only a medical crisis on an unparalleled scale, it involves a crisis of representation itself...<sup>14</sup>

A note published in the *Harvard Law Review* in 1986, describing the stigmatization suffered by people with HIV infection, stated that "in perhaps no other instance would singling out AIDS carriers have as severe consequences as with children in school, and perhaps no other group of carriers is considered less blameworthy."<sup>15</sup> This brief passage signifies much about the construction of disease, the social meaning of AIDS, and the influence this cluster of meanings can have upon social policy and legal analysis. The concern expressed for children with AIDS thinly masks the author's participation in the "crisis of representation" that dominates our understanding of AIDS; the language of innocence and guilt, and their companions, blame, punishment and retribution, have little to do with effectively addressing the public health crisis of AIDS. But this language has everything to do with our social understanding of disease, and it is this crisis that must first be understood before an informed and compassionate response to HIV disease is possible.

#### A. *Historical Construction of Disease: Cancer and Venereal Disease*

An examination of the history of the social construction of disease provides insight into the meaning that has been grafted onto AIDS since the disease was first recognized.<sup>16</sup> Susan Sontag first explored the social construction of cancer in her polemic essay published in 1979, *Illness as Metaphor*.<sup>17</sup> More recently, she has expanded her discussion of disease to include the new phenomenon of AIDS in her essay, *AIDS and Its Metaphors*.<sup>18</sup> Sontag notes that throughout history humans have always sought

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<sup>13</sup>As previously noted, the term "HIV disease" is employed in this paper to describe the entire continuum of progressive conditions that result from HIV infection, from the initial symptoms associated with seroconversion, to asymptomatic HIV infection, to symptomatic HIV infection, and finally, to AIDS. See *infra*, note 3.

<sup>14</sup>S. Watney, *Policing Desire: Pornography, Aids, and the Media* (Minneapolis: University of Minnesota Press, 1987) 9.

<sup>15</sup>Note, "The Constitutional Rights of AIDS Carriers" (1986) 99 Harv. L. Rev. 1274 at 1292.

<sup>16</sup>See generally E. Fee & D.M. Fox, eds, *AIDS: The Burdens of History* (Berkeley: University of California Press, 1988).

<sup>17</sup>S. Sontag, *Illness as Metaphor* (Toronto: Random House, 1979).

<sup>18</sup>S. Sontag, *AIDS and Its Metaphors* (New York: Farrar, Straus & Giroux, 1989).

to attach moral significance to illness; in particular, diseases without a cure and with an unknown and perhaps highly contagious mode of transmission are most susceptible to a moral construction. Metaphors for evil have traditionally been projected onto these diseases, "and the disease (so enriched with meanings) is projected onto the world."<sup>19</sup>

For example, cancer is surrounded by a cluster of social meanings and metaphors, many drawn from the language of warfare. Tumours are designated "malignant" and "invasive", the body's "defenses" are rarely adequate to destroy the invader, and patient's are "bombarded" with radiotherapy to "kill" the cancer cells.<sup>20</sup> The uncertain and largely unknown causality of cancer attaches further significance; punishment metaphors spring up to account for the murky origin of the disease, the cancer "victim" is seen as somehow responsible for his illness, attracting the disease by his lifestyle, diet, sexual repression, introspection, self-indulgence or fear of disease.<sup>21</sup> Despite the progress in treating cancer, references to death dominate the language of cancer to the point where cancer becomes a metaphor for death itself.<sup>22</sup>

Unlike cancer, the cause of AIDS has been identified.<sup>23</sup> However, popular conceptions of AIDS continue to overlook the fact that the disease is caused by a virus and insist on presenting a theory of causation that is based on personal morality.<sup>24</sup> Although modern virology allows us to define AIDS as a clinical entity, its mode of transmission and fatality level "have mobilized deeply felt social attitudes that relate only tangentially to the virologist's understanding of the syndrome."<sup>25</sup> As Allan Brandt has pointed out,

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<sup>19</sup>S. Sontag, *Illness as Metaphor*, *supra*, note 17 at 58. Sontag refers to these diseases as "master illnesses" [at 72].

<sup>20</sup>*Ibid.* at 63.

<sup>21</sup>*Ibid.* at 59.

<sup>22</sup>*Ibid.* at 18.

<sup>23</sup>See *supra*, note 3.

<sup>24</sup>J.L. Dolgin, "AIDS: Social Meanings and Legal Ramifications" (1985) 14 Hofstra L. Rev. 193 at 197.

<sup>25</sup>C.E. Rosenburg, "Disease and Social Order in America: Perceptions and Expectations", in *AIDS: The Burdens of History*, *supra*, note 16, 12 at 28: "If diseases can be seen as occupying points along a spectrum, ranging from those most firmly based in a verifiable pathological mechanism, to those, like hysteria or alcoholism, with no well-understood mechanism but with a highly charged social profile — then AIDS occupies a place at both ends of that spectrum."

A disturbing display of this pervasive construction of AIDS can be found in a recently published article where the author asserts in his opening paragraph that AIDS "is in many ways a product of modern society", and points an accusing finger at "the rather liberal sexual attitudes which prevailed in certain areas of the American homosexual and bisexual community in the 1970's and early 1980's... [and] more recently, heterosexuals who engage in multiple, indiscriminate sexual activity." B. Kussner, "AIDS-Based Discrimination in the Workplace: Issues and Answers" (1989) U.T. Fac. L. Rev. 383 at 384. AIDS, of course, is not a "product" of modern society, it is a product of HIV infection. Nevertheless, the public mind continues to ignore this verifiable pathogenesis, and instead prefers to assiduously maintain the condemning construction of AIDS as a disease somehow "produced" by changing sexual behaviour.

this treatment of AIDS mirrors that of syphilis in the early 20th century.<sup>26</sup> Like AIDS, the cause of syphilis was well known. That did not limit, however, its capacity for metaphor and stigma. In fact, exactly because venereal disease was known to be primarily sexually transmitted, it acquired a powerful metaphorical meaning. Brandt argues that in order to understand more fully the phenomenon of disease it is important to look beyond the search for the elusive "magic bullet" — specific treatments to eliminate a disease — we must as well re-examine the "social constructions" of disease and understand "the way disease is influenced by social and cultural forces — issues of class, race, ethnicity, and gender..."<sup>27</sup> As Charles E. Rosenberg notes, the social understanding of disease is a function of both the medical phenomenon and social perception of disease: "This process of interaction between phenomenon, perception and policy is important not only to medicine but also to social science generally."<sup>28</sup> In this complex interaction of phenomenon and perception, venereal disease came to be seen as a punishment for those who had willfully violated the moral and sexual code, and, even more importantly, this construction significantly influenced and distorted the practice and policy surrounding the treatment of individuals with venereal disease as well as the efforts to contain the spread of the infection.<sup>29</sup>

For example, doctors came to define what they called *venereal insontium*, or venereal disease of the innocent, in particular gonorrheal blindness of the newborn, which as late as 1910 accounted for as many as 25 per cent of all the blind in the United States.<sup>30</sup> The language of innocence and guilt, retribution and blame, came to characterize venereal disease. It was also a popular belief in the early 20th century, a period of enormous immigration to North America, that immigrants, "a large foreign population with lower ideals",<sup>31</sup> were bringing venereal disease into the country. Although there was no evidence to support this conclusion, the fact of its widespread currency underscores the class tensions of the time, and how these pressures provided yet another convenient forum to account for the incidence of disease.

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<sup>26</sup>A.M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States Since 1880*, 2d ed. (New York: Oxford U. Press, 1987) 183-204.

<sup>27</sup>*Ibid.* at 4-5.

<sup>28</sup>C.E. Rosenberg, "Disease and Social Order in America: Perception and Expectations", *supra*, note 25 at 30.

<sup>29</sup>Brandt, *supra*, note 26 at 6.

<sup>30</sup>A.M. Brandt, "AIDS: From Social History to Social Policy" (1986) 14 *Law, Medicine and Health Care* 231 at 231.

<sup>31</sup>*Ibid.* at 232, citing Howard Kelly, a leading gynecologist at Johns Hopkins in "Social Diseases and their Prevention" (1910) 1 *Social Diseases* 17; H. Kelly, "The Protection of the Innocent" (1907) 55 *American Journal of Obstetrics* 477.

In an even more dramatic display of social tension, in 1918 the United States Congress allocated more than \$1 million for the detention and isolation of venereal carriers; during the war more than 30,000 prostitutes were so detained.<sup>32</sup> Notwithstanding this policy, rates of venereal disease increased dramatically during World War I. Gender discrimination thus joined class tensions and the language of retribution, completing the complex and multi-layered vocabulary and social context of venereal disease.

Understanding the social construction that has been grafted onto venereal disease and cancer is an important step in decomposing the moral meaning that has been given to AIDS. Although cancer and venereal disease may be said to transform their victims into a stigmatized class, AIDS might be described as the first disease that appears to take classes already stigmatized and make them into the disease's apparently unique victims. Like venereal disease, the further link with sexuality and blood makes AIDS particularly susceptible to metaphorical use.<sup>33</sup> The language of AIDS is thus doubly dense with meaning.

### ***B. AIDS: The "Gay Plague"***

Perhaps the most resilient construction of AIDS, and one that has overwhelmingly dominated the imagery of this disease since it was first identified in 1981, is the identification of AIDS as the "gay plague".<sup>34</sup> The first reported cases of AIDS were exclusively among gay men and the term "gay-related immune deficiency", although not used officially by the Atlanta Centers for Disease Control, soon came into use.<sup>35</sup> At the time, the causality of AIDS was unknown and, as foreseen by Sontag, moral metaphors quickly sprang into use to "explain" AIDS. The most widespread claim, and one still popular despite the fact that the cause of AIDS has now been identified, was the claim that AIDS was linked to the legendary "promiscuity" of gay men, fostering the impression that promiscuity itself was the cause of AIDS. It is now clear that HIV, the cause of AIDS, can be transmitted from an infected to an uninfected individual in one sexual encounter, one blood transfusion,

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<sup>32</sup>*Ibid.* at 233.

<sup>33</sup>D. Altman, *AIDS in the Mind of America* (Garden City, N.Y.: Anchor Press, 1986) at 194.

<sup>34</sup>*Ibid.* at 30-57. See also T.R. Mendicino, "Characterization and Disease: Homosexuals and the Threat of AIDS" (1987) 66 N.C. L. Rev. 226.

<sup>35</sup>Although AIDS was first identified in gay men, it probably did not affect gay men first, and it now appears that intravenous drug users were dying of AIDS in New York City throughout the 1970s and 1980s. The disease was only identified when it was first seen in middle-class gay men; an "epidemiology equally skewed by class and racial bias" failed to identify AIDS-related deaths in IV drug users prior to the appearance of the disease in gay men. See D. Crimp, "How to Have Promiscuity in an Epidemic" (1987) 43 October 237 at 249, where he cites a study that appeared in *The New York Times*, (22 October 1987) B1 ("AIDS Deaths in New York Are Showing New Patterns").

or the single use of an unclean needle. The more one engages in these high risk activities, the higher one's risk of infection becomes; "promiscuity", and in particular "gay promiscuity", does not cause AIDS.<sup>36</sup>

Nonetheless, this initial construction of AIDS continues to influence profoundly the political and social response to AIDS.<sup>37</sup> Notwithstanding the fact that, for example, the incidence of AIDS in Central Africa has little to do with homosexual activity,<sup>38</sup> the equation "AIDS=gay" persists. Moreover, the rate of transmission of HIV among the gay population of both Canada and the United States has been significantly reduced because gay men have altered their high risk activities.<sup>39</sup> In the United States, the transmission of HIV is now highest among IV drug users and their sex partners;<sup>40</sup> evidence of this can already be seen in New York City where the majority

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<sup>36</sup>See *supra*, note 3. "When an epidemiologist notes that the incidence of AIDS correlates with numbers of sexual contacts, he may be speaking in terms of likelihoods; to many of his fellow Americans he is speaking of guilt and deserved punishment." [C.E. Rosenberg, "Disease and Social Order in America", *supra*, note 25 at 29.]

<sup>37</sup>R. Shilts' book *And The Band Played On* (New York: St. Martin's Press, 1987), an account of the first years of the AIDS epidemic, describes the tragically inadequate response of the American government to the AIDS crisis — a response hugely influenced by the perception that this disease was less important because it only affected homosexuals. Shilts details the chronic lack of funding for the Centers for Disease Control in the first years of the epidemic [at 291, 328-9, 397-8], the lack of will on the part of both scientists and politicians to address a "homosexual" disease [at 110], the refusal by President Reagan even to mention the epidemic until over five years after AIDS was identified [at 590-595], and the total lack of media attention to the disease in the first years [at 110], until AIDS was seen as a potential threat to the "general", *i.e.* heterosexual, population [at 126]. The lives that might have been saved had the American political and medical structure responded more quickly and effectively, particularly with information on how to prevent HIV transmission, will never be known. Given the average incubation period of HIV infection can be anywhere from 8-13 years [*supra*, note 3], the people infected during these critical years of inaction, 1981-83, are the same people who may develop AIDS today.

<sup>38</sup>In Africa, HIV is primarily transmitted through heterosexual activity. See *Confronting AIDS*, *supra*, note 1 at 74-77.

<sup>39</sup>G. Friedland & R. Klein, "Transmission of the Human Immunodeficiency Virus", *supra*, note 3 at 1130. See also W. Winkelstein, *et al.*, "The San Francisco Men's Health Study: Reduction in HIV Transmission among Homosexual/Bisexual Men, 1982-6" (1987) 77 *Amer. J. Pub. Health* 685.

<sup>40</sup>See *Confronting AIDS: 1988 Update*, *supra*, note 3 at 49-52. Attempts to reduce the high risk activities of IV drug users has met with less success than that achieved by gay men although the distribution of clean needles has reduced HIV transmission in Great Britain, Sweden, the Netherlands and Australia. In Canada, needles are freely available and may be purchased in most pharmacies without a doctor's prescription. See "Sexually Transmitted Disease in Canada — 1986" (1988) 14:20 *Canada Diseases Weekly Report*. This policy has not, however, been widely introduced in the United States, although New York City has recently introduced a needle exchange program. See "Study Supports New York's Needle Plan" *The New York Times* (6 June 1988) II:3 and "Needles for Addicts: Test Phase Begins" *The New York Times* (26 June 1988) IV:7.

of AIDS patients are now IV drug users, most of whom are either Hispanic or black.<sup>41</sup>

Although the incidence of AIDS worldwide has little to do with homosexuality, and the Canadian population now most likely at risk is IV drug users, the characterization of AIDS as a "gay disease" is likely to continue at least in Canada for the foreseeable future. Given the lengthy progressive prognosis of HIV disease, up to 13 years or longer between infection with HIV and a diagnosis of AIDS,<sup>42</sup> the number of gay men in Canada who develop AIDS will continue to increase. The majority of these men would have been infected with HIV in the late 1970s and early 1980s, before the virus and its means of transmission was identified. Moreover, the incidence of AIDS among IV drug users has to date been smaller in Canada than in the United States.<sup>43</sup> After 1991 this may begin to change. The incidence of AIDS among gay men will likely decline and, unless HIV transmission via IV drug use is reduced, an increasing number of IV drug users will develop AIDS.<sup>44</sup>

The future of the AIDS epidemic in Canada could come to resemble the present situation in New York City; within four or five years it may no longer be possible to present AIDS as a "gay" disease. The dissolution of this particular image of AIDS might, however, only give rise to an even more disastrous construction: AIDS will become a disease of the underclass, the racial minorities, and IV drug users. One can only fear that the stigma surrounding AIDS may become even more acute, making even more urgent the need to deconstruct the already omnipresent metaphors of AIDS.

### C. AIDS: War against the Other

The function of the war metaphor has already been identified in the construction of cancer; it has an equally profound effect on the meaning of AIDS. The primary element of the war metaphor is, of course, the enemy, in this case HIV. Those housing the enemy, the "carriers", are transformed into the enemy themselves; demands for quarantine, isolation, and identification are all attempts to locate and neutralize the enemy, not unlike the detention of prostitutes during World War I or the Japanese in both Canada

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<sup>41</sup>*Confronting AIDS: Update 1988*, *supra*, note 3 at 51-52; and "Spread of AIDS Abating, But Deaths Will Still Soar" *The New York Times*, (14 February 1988) I:36.

<sup>42</sup>See the discussion at *supra*, note 3.

<sup>43</sup>The incidence of HIV infection via IV drug use is much lower in Canada than in the United States. Only 3.3 per cent of Canadians diagnosed with AIDS are IV drug users as opposed to 19 per cent of Americans. See *AIDS: A Perspective for Canadians*, *supra*, note 2 at 4; and W. Heyward & J. Curran, "The Epidemiology of AIDS in the U.S.", *supra*, note 2 at 78.

<sup>44</sup>See "Sexually Transmitted Disease in Canada", *supra*, note 40 at 10-11.

and the United States during World War II.<sup>45</sup> Disease personified becomes the enemy in our midst, everywhere and yet nowhere, threatening to take over and destroy. As Sontag notes, "authoritarian political ideologies have a vested interest in promoting fear, a sense of the imminence of takeover by aliens- and real diseases are useful material."<sup>46</sup> Disease enhanced by military metaphor "not only provides a persuasive justification for authoritarian rule but implicitly suggests the necessity of state-sponsored repression and violence... the effect of the military imagery on thinking about sickness and health is far from inconsequential. It overmobilizes, it overdescribes, and it powerfully contributes to the excommunicating and stigmatizing of the ill."<sup>47</sup>

The enemy metaphor is another way of expressing the "otherness" of those with HIV disease. A concern continually expressed in accounts of AIDS is that everything must be done to prevent the spread of the infection into the "general population".<sup>48</sup> This term, of course, excludes from the "general population" the over 1.5 million individuals in the United States and Canada who are infected with HIV, a feat that is made even easier by the creation of the "risk groups". Although the concept of risk group was originally epidemiological, its function being to isolate characteristics that are predictive of where a disease is likely to appear so as to contain and prevent it, this category has been used to stereotype and stigmatize people, placing them even further outside the moral parameters of the "general population". Rather than using these epidemiological categories to contact people at risk from HIV infection, the classification has been employed to isolate and condemn.<sup>49</sup> "'Risk group'... revives the archaic idea of a tainted community that illness has judged."<sup>50</sup>

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<sup>45</sup>J. W. Ross, "Ethics and the Language of AIDS", in C. Pierce & D. VanDeVeer, eds, *AIDS: Ethics and Public Policy* (Belmont, Ca.: Wadsworth, 1988) 40 at 44-45. See also D. Altman, *AIDS in the Mind of America*, *supra*, note 33 at 193 where he quotes then Secretary of Health and Human Services in the Reagan Administration Margaret Heckler who, in her speech at the International Conference on AIDS in Atlanta, spoke of "the mobilization of an international war on AIDS" and "training our largest scientific and medical cannon on the AIDS target" and M. Barnes, "AIDS and Mr. Korematsu: Minorities at Times of Crisis" (1988) 8 St. Louis Univ. Pub. L. Rev. 35.

<sup>46</sup>S. Sontag, *AIDS and Its Metaphors*, *supra*, note 18 at 61.

<sup>47</sup>*Ibid.* at 94.

<sup>48</sup>Secretary Margaret Heckler, speaking at an international conference on AIDS in April, 1985, first coined the phrase, saying that "we must conquer [AIDS] before it... threatens the health of our general population." See J.W. Ross, *supra*, note 45 at 45. See also J.Z. Grover, "AIDS: Keywords" (1988) 43 October 17 at 27.

<sup>49</sup>In 1981 when AIDS was first identified, it was characterized as the "gay plague" as it was primarily identified in gay men. The discovery that IV drug users were also affected with the syndrome lead researchers to suspect that a blood-borne virus was the cause of the infection and HIV was first identified in the spring of 1983. Gay men and IV drug users thus form the major "risk groups" for HIV infection, however because membership itself in one of these

The construction of the "Other" permits society to pursue simultaneously two contradictory objectives: being able to distinguish ourselves from the infected makes it easier to ignore them and disregard their suffering. Yet at the same time the potential threat presented by the Other cannot be ignored and it becomes more attractive to stigmatize and isolate "them". If the threat presented were indeed widespread, rather than restricted to certain risk practices and risk "groups", it would not be possible to delimit the "otherness" of the infected — they would become "us". As it became more difficult to distinguish, stigmatize and isolate the Other, our situation would more closely parallel that of the devastating and indiscriminate plagues of former times.<sup>51</sup> But exactly because the risk of HIV transmission is limited, and those most affected have little political power, it becomes more attractive to use extraordinary and violent means allegedly aimed at containing the infection, even if these means bear little relation to any requirement of public health. "Such is the extraordinary potency and efficacy of the plague metaphor: it allows a disease to be regarded both as something incurred by vulnerable 'others' and as (potentially) everyone's disease."<sup>52</sup>

#### D. AIDS as Punishment

The "punishment" metaphor remains another one of the most enduring and disempowering constructions of AIDS.<sup>53</sup> One frequently quoted example is the account of AIDS offered by Patrick Buchanan, conservative

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groups has nothing to do with possible infection and the focus is gradually shifting from "risk groups" to "risk practices," these being intravenous injections and penetrative sex. The emphasis on risk practices clarifies the means of transmission of HIV, alerts people to the risk of transmission in all penetrative sex, homosexual and heterosexual, and reduces the damaging and inaccurate stigmatization of entire risk groups. See J.Z. Grover, "AIDS Keywords", *supra*, note 48 at 27; and *Confronting AIDS*, *supra*, note 1 at 57-63.

<sup>50</sup>S. Sontag, *AIDS and Its Metaphors*, *supra*, note 18 at 46.

<sup>51</sup>As René Girard notes in his essay "The Plague in Literature and Myth", in *To Double Business Bound: Essays on Literature, Mimesis, and Anthropology* (Baltimore: Johns Hopkins U. Press, 1978) at 136-7: "The plague [in literary and scientific accounts] is universally presented as a process of undifferentiation, a destruction of specificities. . . . The distinctiveness of the plague is that it ultimately destroys all forms of distinctiveness. The plague overcomes all obstacles, disregards all frontiers." Girard goes on to note, however, that despite this undifferentiation, the resolution of the plague requires the identification of a "random victim" or scapegoat, such as the persecutions against the Jews in the Middle Ages [at 148].

<sup>52</sup>S. Sontag, *AIDS and Its Metaphors*, *supra*, note 18 at 64. As with so much of the crisis of representation surrounding AIDS, the construction of the "Other" has proven resilient. A recently published article dimly asserts that "AIDS is not just a disease of homosexuals and drug abusers, rather it has the potential of affecting all of us." M. Gillespie, "AIDS: Detection and Control" (1989) 47 U.T. Fac.L.Rev. 354 at 355. The author blindly reinforces the notion that AIDS would be less important if it were confined to two deprived groups, and only because it is affecting "us" (the author thereby assumes that the reader is a member of her class, social grouping, or sexual orientation) that the disease ought to command "our" attention. Language intimately shapes our understanding of the world—its importance in constructing our perception of AIDS cannot be underestimated.

<sup>53</sup>J.W. Ross, *supra*, note 45 at 41. See also L. Kopelman, "The Punishment Concept of Disease" in *AIDS: Ethics and Public Policy*, *supra*, note 45 at 50.

columnist and former Reagan speechwriter: "The poor homosexuals—they have declared war upon Nature, and Nature is exacting an awful retribution."<sup>54</sup> One need not go to the extreme of quoting Buchanan in order to illustrate the operation of this metaphor, as the above cited Harvard Law Review note illustrates: "blameworthy" belongs to the vocabulary of sin and punishment. Innocent school children ought not to be punished for the sins of the guilty.<sup>55</sup>

In what is perhaps an even more disturbing phenomenon, a number of gay men writing about AIDS have been willing to internalize the construction of AIDS as punishment. Seymour Klienburg thus writes that the "rough poetic justice" of AIDS has reminded gay men of one of the lessons of history: "unfettered sexuality means death, whether through dishonor, the wrath of the gods, or nature itself. We are the heir of those legends. AIDS, like a blotter, has absorbed those old meanings."<sup>56</sup> The power of representation to shape our understanding of AIDS and disempower the vulnerable is most vividly illustrated when even those most injured by this construction are somehow convinced to submit to it.<sup>57</sup>

Although the idea that AIDS is nature's punishment of gay men and IV drug users enjoys widespread currency and has unquestionably influenced public policy,<sup>58</sup> the concept is incoherent. The majority of people

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<sup>54</sup>*New York Post* (24 May 1983).

<sup>55</sup>The punishment metaphor lives on. Then Vice-President George Bush in his campaign for the Presidency, although coming out in favour of the recommendation of the Presidential AIDS Commission that the federal government prohibit discrimination against people with AIDS, stressed that his primary concern was to protect "innocent" children from AIDS-related discrimination. See "Bush Backs Protection of AIDS Victims Rights" *The New York Times* (29 June 1988) I:21.

<sup>56</sup>S. Klienburg, "Life after Death" in *AIDS: Ethics and Public Policy*, *supra*, note 45, 56 at 59.

<sup>57</sup>See also R. Shilts, *And the Band Played On*, *supra*, note 37, for another example of this phenomenon. His book created the infamous "Patient Zero", the story of Gaetan Dugas, the Canadian flight attendant who allegedly "gave us AIDS". As D. Crimp notes in his essay "How to Have Promiscuity in an Epidemic", *supra*, note 35 at 237, Shilts was far more concerned with the creation of a gripping narrative rather than any factual account of AIDS. Shilts, by creating a sexually voracious and murderously irresponsible "patient zero", fed the popular conception of homosexuals; Shilts "offers up the scapegoat for his heterosexual colleagues in order to prove that he, like them, is horrified by such creatures." [at 244].

<sup>58</sup>For example, the United States Commission on Civil Rights recently held hearings to gather information on the "transmissibility of AIDS" (*sic*) in order to determine whether, for example, employment discrimination against people with AIDS could be justified. The inquiry overlooked the fact that the transmissibility of HIV has already been established and that discrimination against people with AIDS is already proscribed by much legislation in the United States

suffering from AIDS in the world are neither homosexual nor IV drug users;<sup>59</sup> if fate has sent the disease to punish either group, it is a most inexact tool. Even if AIDS could be understood as Klienburg's "rough justice," this could do nothing to direct the public debate about AIDS: if AIDS is punishment, how can we be justified in augmenting this retribution through inaction or a violent overreaction? To account for AIDS as nature's justice is only to replace the obscure origin of disease and evil in our world with an even more obtuse explanation. It neither clarifies the origin of AIDS nor provides any direction in dealing with the disease.

A somewhat less extreme expression of the punishment metaphor discusses how people can bring diseases upon themselves by their lifestyles, actions, habits, or thoughts.<sup>60</sup> Smoking, for example, is widely known to cause cancer; those who develop lung cancer after knowingly assuming the risk of smoking are often regarded as somewhat more to "blame" for their illness than other sick people. Nonetheless, it is clear that people with lung cancer are no less deserving of health care than others. In any event, this argument can only have a limited application to AIDS because the majority of individuals who have the disease contacted it entirely unaware of any risk of infection, before the virus was identified and its method of transmission understood. Moreover, those who continue to practise high risk behaviour despite knowledge of the risk, most commonly IV drug users, are presented with the enormous challenge of altering high risk practices which are deeply ingrained and encumbered by social and economic oppression.

These issues are so complex that we cannot assume with any confidence that, even among those who should now be aware of the risk they are taking, we can distinguish between those who "brought" AIDS upon themselves and those not responsible for their illness. And even if this could be done with any certainty, it does not follow that those responsible for their illness ought to be denied health care or treated with less concern. "Nature" may have given the world AIDS, but that in no way can intelligibly inform our response to this epidemic. Blaming the victim, regardless of how irrational it may be, does however serve one timeless function: the creation of a

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[Discussed *infra*, Part III]. The Commission's "Project Proposal," alluding to the punishment metaphor, also noted that the "acts generally responsible for transmitting the virus are often illegal and have traditionally been morally proscribed" and in support cited a number of passages from the Bible such as 1 Timothy 1:9-10: "law is not made for righteous man, but for those who are lawless and rebellious, for the ungodly and sinners, for the unholy and profane. . . and immoral men and homosexuals." See "On AIDS, Panel Battles Some It Wants to Help" *The New York Times* (13 April 1988) I:18.

<sup>59</sup>*Confronting AIDS*, *supra*, note 1 at 73-77.

<sup>60</sup>L.Kopelman, "The Punishment Concept of Disease", *supra*, note 53 at 53.

comforting and differentiating moral rationale to account for the arbitrary tragedy of illness and death.

### *E. The Morality of AIDS*

The entire discourse surrounding AIDS provides a deeply embedded moral content to this illness. "With this illness, one that elicits so much guilt and shame, the effort to detach it from these meanings, these metaphors, seems particularly liberating, even consoling. But the metaphors cannot be distanced just by abstaining from them. They have to be exposed, criticized, belabored, used up."<sup>61</sup> Nonetheless, the popular imagination remains highly resistant to an understanding of AIDS as an arbitrary event causing senseless tragedy, not unlike other diseases such as polio or Legionnaires' Disease which largely escaped the social stigma attached to AIDS or venereal disease. But we do not like to believe that our suffering or the suffering of others has no meaning. People demand a moral construction that permits them to vilify disease, providing the comforting distinction of otherness that offers the illusion of protection.

Although it is vital to our understanding of AIDS to resist its popular construction, the tragedy of this disease does not lack a profoundly moral message. As one doctor who provides care for people with AIDS in New York City expressed, AIDS "...is not symbolic of anything. There are no 'victims', because there is no crime. There are no 'innocents', because there are no 'guilty', and there is no blame, because there has been no intention to cause harm. There are only sick men, women, and children, all of whom need our help."<sup>62</sup>

## **II. HIV Testing, Reporting, and Contact Tracing in Canada**

Given the condemning moral construction of AIDS, the compelling interest in securing anonymous HIV tests hardly needs to be emphasized. The potential for social stigmatization and AIDS-related discrimination is enormous. Yet the public interest in containing the spread of HIV infection is equally pressing. The question for policy-makers becomes: How best can these two objectives be achieved? A responsible legal, medical, and social policy is one that avoids the rhetorical construction of AIDS, protects the privacy of those infected, and effectively prevents the spread of HIV infection. The question of securing an appropriate balance is not the exclusive terrain of public health officials; the *Charter* guarantees of equality also provide the courts and the legal profession with the opportunity to partic-

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<sup>61</sup>S. Sontag, *AIDS and Its Metaphors*, *supra*, note 18 at 94.

<sup>62</sup>D. Shenson, "When Fear Conquers: A Doctor Learns about AIDS from Leprosy", *The New York Times Magazine* (28 February 1988) 36 at 48.

ipate in this social and political debate. The constitutional parameters of the mandatory reporting of HIV infection in Canada are thus brought into question.

#### **A. Mandatory Reporting of HIV Infection and Contact Tracing in Canada**

Matters of public health typically fall under provincial jurisdiction as a "local or private" matter within s. 92(16) of the *Constitution Act, 1867*.<sup>63</sup> Although there are wide divergences in legislation and practice between and within the provinces, all provinces currently require that all diagnosed cases of AIDS be reported with identifiers to public health officials. With the exception of the Provinces of Quebec, Alberta, and British Columbia, all remaining provinces and territories<sup>64</sup> require that in addition to the reporting of cases of AIDS, all findings of HIV seropositivity must be reported with identifiers to public health officials.<sup>65</sup> To date, only the Province of Quebec has expressly adopted a policy favouring the provision of anonymous HIV testing as a means to encourage individuals to determine their antibody status and seek preventive counselling.

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<sup>63</sup>See generally *Schneider v. R.*, [1982] 2 S.C.R. 112. If the AIDS epidemic has a national dimension (such as air or water pollution) or is an "epidemic of pestilence" (as suggested in *Toronto Electric Commrs. v. Snider*, [1925] A.C. 396 at 412), it could fall within federal Parliament's peace, order, and good government power. See P. Hogg, *Constitutional Law of Canada*, 2d ed. (Toronto: Carswell, 1985) at 405-6.

<sup>64</sup>Saskatchewan, Manitoba, Ontario, Nova Scotia, New Brunswick, Newfoundland, Prince Edward Island, the Northwest Territories and the Yukon .

<sup>65</sup>See Alberta *Public Health Act* S.A. 1984, c.P-27.1, as am. S.A. 1988, c.41, s.31(1), and *Communicable Diseases Regulation*, Alta. Reg. 238/85, Schedules 1 & 3; British Columbia *Health Act Communicable Disease Regulation*, B.C. Reg. 4/83, s.2 & Schedule A; Manitoba *Regulation Respecting Diseases and Dead Bodies*, R.R.M. P210-R2, ss.2(1), 5 & 40; New Brunswick *General Regulation -- Health Act*, N.B.Reg. 84-283, ss. 96(1) & (2); Newfoundland *Communicable Diseases Act* R.S.N. 1970 C.52, ss. 3-5 and Schedule; Nova Scotia *Regulations in Respect of the Communicable Diseases*, N.S. Reg.171/85, ss.2 & 11(15A); Ontario *Health Protection and Promotion Act, 1983*, *supra*, note 10, c.10, ss. 25-29, O.Reg. 161/84, s.1, and O. Reg. 162/84, s.1; Prince Edward Island *Notifiable and Communicable Diseases Regulations*, P.E.I. Reg. EC330/85, ss. 6, 7 & 17; Quebec *Public Health Protection Act*, S.R.Q., c.P-35, s.5, and R.R.Q. 1980, c.P-35, s.30 & Schedule 13; Saskatchewan *Regulations Governing Control and Notification of Communicable Disease*, Sask. Reg. 307/69, ss. 1(1)(o), 2 & 3; Northwest Territories *Public Health Act*, R.S.N.W.T. 1984, c.P-10, Schedule A, and *Communicable Diseases Regulations*, R.R.N.W.T. 1980, Reg. 212, ss. 4 & 5; and Yukon *Public Health Act*, Y.T.O.I.C. 1987/214, Schedule 1, and *Communicable Diseases Regulation*, Y.T.O.I.C. 1961/48, s.4. This information was supplied by Julie Hamblin at the Institute of Comparative Law, McGill University. See J. Hamblin, *Public Health Legislation and HIV/AIDS: Confrontation in Compulsory Case-Reporting* (LL.M. Thesis, Institute of Comparative Law, McGill University, 1989) [unpublished]. See also, D.G. Casswell, "Disclosure By a Physician of AIDS-Related Patient Information: An Ethical and Legal Dilemma" (1989) 68 Can. Bar Rev. 225 at 255 where the author provides a table of provincial legislation.

There are essentially three different public health models available for locating and notifying the contacts of an HIV infected person (known as the "index").<sup>66</sup> "Active contact tracing" attempts to notify as many contacts of an index as possible about potential exposure to HIV. Health officials solicit the names of a patient's contacts and then warn them about exposure without revealing the identity of the index. Contacts are advised to undergo testing and seek counselling about preventive measures, and both services are usually provided by the intervening health official.

Where active contact tracing may be unfeasible, given the size of the infected population and the inability to identify or locate anything more than a minority of the contacts, health officials may adopt a program of "limited contact tracing" which is primarily aimed at notifying individuals who might be unaware of any risk of infection, such as female sexual partners of closeted bisexual men and sexual partners of closeted IV drug users.

"Voluntary contact tracing", the third option available, involves encouraging the index to notify contacts personally and encourage them to seek testing and counselling. Health officials do not usually seek to participate in the process but they will usually offer to assist the index upon request.<sup>67</sup>

Only the Province of Ontario has adopted an active contact tracing programme for HIV infection, the most invasive of the three available options. The remaining provinces, though practices vary widely, in general have adopted largely informal contact tracing procedures, usually focussing on voluntary contact tracing and, in some circumstances, a limited contact tracing program confined to populations who may unknowingly be at risk for HIV infection. Because the Province of Ontario has thus distinguished itself in adopting the only active HIV contact tracing program in Canada, in addition to being the only province to enforce aggressively the HIV mandatory reporting requirements under the Ontario *Health Promotion and Protection Act*, the Ontario program provides the most comprehensive and useful model for the study of the public health consequences of mandatory reporting of HIV infection and contact tracing.

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<sup>66</sup>For further elaboration of these models, see Intergovernmental Health Policy Project, George Washington University, *AIDS: A Public Health Challenge* (Washington, D.C.: The George Washington U., 1987) vol. 1 [hereinafter *AIDS: A Public Health Challenge*] at 3-15 — 3-35.

<sup>67</sup>For example, the State of Minnesota has initiated a voluntary contact tracing program. See the discussion below in Part III.

## B. *The Ontario Health Protection and Promotion Act*

The *Health Protection and Promotion Act*<sup>68</sup> establishes a comprehensive legislative scheme for the provision of health programs and services and the prevention of the spread of disease in Ontario. Part IV of the Act outlines reporting requirements<sup>69</sup> and public health procedures for "virulent", "communicable", and "reportable" diseases; the Minister of Health may make regulations specifying all three kinds of diseases.<sup>70</sup> The Medical Officer of Health of the local Board of Health is given broad powers to monitor and control the spread of virulent and communicable diseases; a reportable disease does not give rise to the same broad powers. AIDS has been defined by regulations to be both a reportable<sup>71</sup> and a communicable<sup>72</sup> disease but not a virulent disease.

The Act requires that operators of laboratories report "each case of a positive laboratory finding in respect of a reportable disease"<sup>73</sup> and physicians, hospital administrators, and school principals are required to report cases where a person "is or may be infected with an agent of a communicable disease...".<sup>74</sup> This provision thus far has been interpreted by the Department of Public Health of the City of Toronto as requiring the reporting of all findings of HIV seropositivity.<sup>75</sup> Failure to make a required report under

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<sup>68</sup>*Supra*, note 10.

<sup>69</sup>Physicians are under a number of different obligations to report medical findings to various government agencies. For example, the *Child and Family Services Act, 1984*, S.O. 1984, c. 55, requires physicians to report cases of suspected child abuse to the Children's Aid Society and the *Highway Traffic Act*, R.S.O. 1980, c.198, s.177, requires physicians to report patients who have medical conditions that may make it dangerous for them to drive to the Registrar of Motor Vehicles. See generally G. Sharpe, *The Law and Medicine in Canada*, 2d ed. (Toronto: Butterworths, 1987) at 184-86.

<sup>70</sup>*Health Protection and Promotion Act, supra*, note 10, s.96.

<sup>71</sup>O.Reg. 162/84.

<sup>72</sup>O.Reg. 161/84.

<sup>73</sup>*Supra*, note 10, s.29(1). The results of HIV blood screening tests done by the Canadian Red Cross are also reported to the Medical Officer of Health [interview with Joanne Ackery, Public Health Nurse responsible for HIV contact tracing with the Department of Public Health for the City of Toronto (18 July 1988)].

<sup>74</sup>*Ibid.*, ss. 25-28.

<sup>75</sup>According to Dr A.S. Macpherson, Medical Officer of Health for the City of Toronto, there is no question that "[s]ince the majority of individuals with antibody to HIV also carry the virus, an individual seropositive for HIV antibody 'is or may be infected with the agent of a communicable disease' and must be reported." Dr Macpherson informed physicians in Toronto of their legal duty to report cases of patients who are HIV seropositive in an undated letter widely distributed to Toronto area physicians in 1987. See also College Notice of The College of Physicians and Surgeons of Ontario (Issue No.12, August 1987) informing physicians of their obligations to report findings of HIV seropositivity and AIDS.

the Act is an offense under the Act and punishable by a fine upon conviction.<sup>76</sup>

### *C. Information Reported*

The information to be included in a report to the Medical Officer of Health is specified in the Regulations under the Act.<sup>77</sup> The report must include the name and address of the patient and any "such additional information respecting the reportable disease or communicable disease, as the case may be, as the Medical Officer of Health considers necessary."<sup>78</sup> The regulation further specifies the information that must be reported for specific diseases, including AIDS: most importantly, the "risk classification" of the patient must be reported.<sup>79</sup>

The provincial government in turn reports cases of full-blown AIDS to the Federal Centre for AIDS in Ottawa. The province does not report cases of individuals who are seropositive but have not developed AIDS, nor does the Federal Centre for AIDS maintain files with the names of the individuals who have AIDS. The Federal Centre uses only the initials of the patient and the date of birth to identify its files and prevent duplication.<sup>80</sup>

The actual procedure by which the provincial government is usually informed of seropositive results is as follows. Any physician may order an HIV test; occasionally the test is even performed as part of a routine series of blood tests without expressly securing the patient's consent for an HIV

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<sup>76</sup>*Supra*, note 10, s.99(2) and s.100. If failure to comply with these requirements resulted in the infection of a third person, the physician might also be liable in tort for breach of a statutory duty or negligence. For example, a recent Supreme Court of Ontario decision broadened the potential liability of a taxi driver who suffered a fatal heart attack while driving thereby injuring another driver. See *Dobbs v. Mayer Estate*, (1985) 9 O.A.C. 124, 32 C.C.L.T. 191 (Div Ct.). Given that the driver would have been suffering considerable pain prior to the accident, the court held him liable in negligence. Although the taxi driver's physician was not sued, given that the physician has the statutory obligation to inform the Ministry of Transportation of patients with an illness that may make it hazardous for them to drive, it is possible that a physician could be also liable under these circumstances. See G. Sharpe, *The Law and Medicine in Canada*, *supra*, note 69 at 186-7.

<sup>77</sup>O.Reg. 490/85.

<sup>78</sup>O.Reg. 490/85, s. 1(2).

<sup>79</sup>O.Reg. 490/85, s. 5.

<sup>80</sup>Telephone interview with Penny Neult of the Bureau of AIDS Prevention and Services Programs of the Federal Centre for AIDS (18 July 1988). The "AIDS Adult Case Report Form" issued by Health and Welfare Canada and presently employed in Ontario to report cases of AIDS includes the patient's name and "social and risk factors". The copy of the form that is sent to the Federal Centre for AIDS deletes the section including the patient's name and address. A copy of this form was provided to me by Mr Fred Ruf of the AIDS Prevention Program of the City of Toronto Department of Public Health (19 July 1988).

test.<sup>81</sup> The physician fills out a form prepared by the Ontario Ministry of Health for the purposes of HIV antibody testing. This form includes either the name or initials of the patient, the date of birth, the name of the attending physician, and the risk group of the patient.<sup>82</sup> The risk group category is requested largely for testing purposes. The test sequence is as follows. Two "ELISA"<sup>83</sup> tests are performed on the blood sample and if both are negative and the person does not fall into one of the risk group categories, the testing sequence ends. However, if either test is positive, or even if both are negative but the person is a member of a risk category, the sequence proceeds to the more expensive and specific "Western Blot"<sup>84</sup> test. If the results of this latter test are positive, a copy of the request form with the positive result is then forwarded directly to the Medical Officer of Health by the laboratory, pursuant to the requirements of the *Health Protection and Promotion Act*.<sup>85</sup> About one half of these forms include the name of the patient and the remaining forms only provide the patient's initials.<sup>86</sup> The Medical Officer of Health then contacts the physician in order to complete an "HIV Follow-Up Information Form".<sup>87</sup> This form includes the results of previous HIV antibody tests, the patient's initials, whether the test was done any-

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<sup>81</sup>See "Concern Growing Over 'Non-Consent' AIDS Tests" *The Toronto Star* (7 January 1988) A4. It appears that physicians can rely upon the implied consent by the act of surrendering blood for diagnostic purposes. See generally G. Sharpe, *The Law and Medicine in Canada*, *supra*, note 69 at 30-32. Nonetheless, the *CBA Report*, *supra*, note 6 at 23-24, recommends that physicians get the patient's consent before ordering the test "given the current potential for prejudice to the individual tested".

<sup>82</sup>I conducted an interview with Dr L. Yuan, AIDS physician in the Downtown Health Area of the City of Toronto (17 March 1988), and she provided me with information about the current practice of the Ministry of Health. Dr Yuan works for the Department of Public Health of the City of Toronto under Dr Macpherson, the Medical Officer of Health for the City of Toronto, and is responsible for the contact tracing program in the area.

<sup>83</sup>The ELISA test is simple, inexpensive and highly sensitive, which means that the ELISA test will almost certainly detect the presence of HIV antibodies, however because the test is so sensitive it frequently reacts to something else in the blood and produces a positive result even absent the presence of HIV antibodies. See J. Petricciani, "Licensed Tests for Antibody to Human T-Lymphotropic Virus Type III: Sensitivity and Specificity" (1985) 103 *Annals of Internal Medicine* 726.

<sup>84</sup>The Western Blot test is much more expensive than the ELISA and much more specific, which means that if the Western Blot test is positive, the blood sample almost certainly contains the HIV antibody. The Western Blot is not, however, as sensitive as the ELISA test and may fail to detect the presence of the antibody. For these reasons, the two tests are always done in conjunction with one another and together the two tests provide a highly accurate result. See Petricciani, *ibid.* at 726-9.

<sup>85</sup>*Supra*, note 10, s.29.

<sup>86</sup>Dr Yuan, *supra*, note 82.

<sup>87</sup>A copy of this form was provided to me by Dr Yuan.

mously,<sup>88</sup> the possible sources of infection (sex with an infected or "high risk" person, a blood product recipient, or IV drug use), and the possible sexual contacts or IV needle partners in the last five years.

#### *D. Powers of the Medical Officer of Health*

Once a communicable disease such as AIDS has been reported to the Medical Officer of Health, he may consider evoking his extensive powers under the Act, including the power to close premises,<sup>89</sup> to order the isolation of a person "infected with the agent of a communicable disease",<sup>90</sup> to order a person to submit to a medical examination to determine whether he is infected,<sup>91</sup> and to require that an infected person "conduct himself in such a manner as not to expose another person to infection."<sup>92</sup>

The Medical Officer of Health also has the power to apply to a provincial offences court to enforce an isolation order with respect to a communicable disease,<sup>93</sup> but the Act does not grant the court the power to order a person to be examined for a communicable disease or order a person not to expose others to the risk of infection.<sup>94</sup> Nonetheless, the Medical Officer of Health could make either of these orders by his own authority and can enforce them under Part IX of the Act which provides for a fine of up to \$5,000 for every day that a person fails to obey an order made under the Act.<sup>95</sup>

Most importantly, for the purposes of this paper, the Act permits the disclosure of any information collected under the Act "where disclosure is made for the purposes of public health administration,"<sup>96</sup> thereby permitting

<sup>88</sup>This is an odd question given that anonymous testing is not legally available in Ontario. The question may refer to whether the patient's name was given on the request form or only the patient's initials were employed.

<sup>89</sup>*Health Protection and Promotion Act, supra*, note 10, s.22(4)(a).

<sup>90</sup>*Ibid.*, s.22(4)(c).

<sup>91</sup>*Ibid.*, s.22(4)(f).

<sup>92</sup>*Ibid.*, s.22(4)(h). If AIDS were classified as a virulent disease, which it presently is not, the Medical Officer of Health would have the further power to order the infected person to place himself under the care and treatment of a physician.[s. 22(4)(g)]

<sup>93</sup>*Ibid.*, ss. 36(2) and 35(3)(a). A detention order is valid for four months [s.36(7)], and upon application by the Medical Officer of Health the order may be extended for further four month periods of detention if the person continues to be infected and continues to present a "significant threat to public health" [s.36(11)(a)(b)]. Any person to whom an order made by the Medical Officer of Health is directed is entitled to a hearing by the Health Protection Appeal Board [s.43] with a further appeal available to the Divisional Court [s.45].

<sup>94</sup>The court may only issue such orders with respect to virulent diseases [*Ibid.*, s.35(2)]. The extensive enforcement provisions of s.35 would apply, however, with "necessary modifications", to persons infected only with a communicable disease if that person had failed to comply with an order to isolate himself [s.36(2)].

<sup>95</sup>*Ibid.*, ss. 99-100.

<sup>96</sup>*Ibid.*, s.38(1)(c).

the Medical Officer of Health to proceed with contact tracing. The Act does not expressly permit the Medical Officer of Health to compel individuals infected with a communicable disease to reveal the names of their contacts; however, the medical officer can order an infected person to "conduct himself in such a manner as not to expose another person to infection"<sup>97</sup> and it is possible that this could be interpreted as requiring the patient to cooperate with contact tracing by revealing the names of his or her contacts.

### *E. Contact Tracing*

Once the physician has completed the required "HIV Follow-Up Information Form", the Medical Officer of Health then asks the physician if he or she is willing to perform contact tracing or if he or she would prefer that the Medical Officer of Health undertake the task.<sup>98</sup> The physician is only able to perform the contact tracing with the consent of the patient; any disclosure without the patient's consent would likely constitute professional misconduct on the part of the physician.<sup>99</sup> Only the Medical Officer of Health may perform contact tracing in the absence of patient consent. As a result, if the physician is unwilling to perform the contact tracing or lacks the necessary patient consent, the Medical Officer of Health will request the name of the patient (the "index") and names of the patient's contacts, if the medical officer does not already have that information. In sum, if a patient refuses to consent to contact tracing, his or her identity must be reported to the Medical Officer of Health who will, in turn, pursue an active contact tracing program.

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<sup>97</sup>*Ibid.*, s.22(4)(h).

<sup>98</sup>As many as 90 per cent of doctors agree to perform the contact tracing themselves [Joanne Ackery, *supra*, note 73].

<sup>99</sup>Regulation 448 under Ontario's *Health Disciplines Act*, R.R.O. 1980, s.27(22) defines professional misconduct as including "giving information concerning a patient's condition or any professional services performed for a patient to any person other than the patient without the consent of the patient unless required to do so by law." See also *Health Protection and Promotion Act*, *supra*, note 10, s.38 which provides that "No person shall disclose to any other person the name of or any other information that will or is likely to identify a person in respect of whom a ... report is made in respect of a ... reportable disease..." Once a physician has reported the name of a patient with HIV infection, under s.38 this physician would be prohibited from releasing this information to any other party.

The physician may also incur civil liability for disclosing confidential information without the patient's consent, such as actions for defamation, breach of contract, breach of statute, and negligence. See generally G. Sharpe, *The Law and Medicine in Canada*, *supra*, note 69 at 181.

The "duty to warn", which imposes liability on a physician for failing to disclose medical records where disclosure could prevent imminent harm to a third person, does not as yet exist in Canadian law [*Ibid.* at 181-2]. See below, Part III for a discussion of the Canadian and American law on duty to warn. See also below, Part III for a detailed discussion of an alternative contact tracing program where the physician would be primarily responsible to perform contact tracing.

The Ministry of Health had previously pursued a limited contact tracing program which focused only on informing "high priority" contacts — essentially any contacts outside of gay males, such as female partners of bisexual men or sexual partners of IV drug users — who might be unaware of their risk of HIV infection. It was assumed that gay sexual partners are "most likely aware of their risk of exposure."<sup>100</sup> This policy is, however, no longer in effect and the Ministry has implemented an active contact tracing program whereby the contacts of all seropositive individuals, including gay men, are now treated as high priority.<sup>101</sup>

It may be difficult for the physician to know about the patient's contacts unless the patient is willing to cooperate and provide this information.<sup>102</sup> However, it is within the authority of the Medical Officer of Health to require physicians to release this information even without the patient's cooperation or consent, if any of this information is available to the physician.<sup>103</sup> In many cases it is likely that the physician will be aware of some of the patient's sexual contacts, especially in the case of married patients. As noted, it is even possible that the medical officer, by ordering a patient to conduct himself so as "not to expose another person to infection", could require that a patient cooperate with contact tracing by revealing the names of his or her contacts.

#### *F. The Prejudicial Impact of Mandatory Reporting*

Given the condemning moral construction that has been grafted onto AIDS, and the potential for social stigmatization and discrimination that can result if HIV-related information is disclosed, the prejudicial effects of a program which ensures, at the very least, that the name of seropositive individuals and their "risk group" is reported to the government, hardly need comment. Government records providing the names of seropositive individuals, homosexuals, and IV drug users raise legitimate concerns; the possibility of highly prejudicial government disclosure of this information cannot be dismissed.

For example, the present provisions of the *Health Promotion and Protection Act* provide only the loosest confidentiality provisions: information collected under the Act can be disclosed "for the purposes of public health"

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<sup>100</sup>See Ontario Provincial Advisory Committee on AIDS, *Statement on Contact Tracing of Individuals with HTLV-III/LAV Infection*, (18 April 1986).

<sup>101</sup>Dr Yuan, *supra*, note 82.

<sup>102</sup>*Ibid.*

<sup>103</sup>O.Reg. 490/85 s.1(2) provides that the Medical Officer of Health may require that a physician report any additional information considered necessary.

and for proceedings under, for example, the *Criminal Code*.<sup>104</sup> Given that IV drug use is criminal behaviour,<sup>105</sup> and the transmission of HIV could in some circumstances result in criminal charges,<sup>106</sup> the release of this information in criminal proceedings would be extremely damaging.<sup>107</sup>

The very real possibility of unauthorized disclosure, as examined by Mr Justice Krever in his 1980 landmark inquiry into the confidentiality of health information, is equally troubling.<sup>108</sup> He noted that between 1976 and 1977, medical information in Ontario was regularly obtained by insurance companies and lawyers by improper means, suggesting the existence of an industry in the trafficking of medical information.<sup>109</sup> The *Krever Report* also referred to a 1977 incident where a computer operator at the Ministry of Health "had run the computer tape containing the names of persons reported as having venereal disease, for fun."<sup>110</sup> There is no reason to believe that similar unauthorized disclosures could not occur with the HIV infection records of the Ministry, which could result in a wide range of AIDS-related discrimination by employers, insurance companies, and landlords.

The active contact tracing program pursued by Ontario public health officials, which permits the disclosure of HIV-related information without

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<sup>104</sup>Concerns about the confidentiality of information collected by the government under the *Health Promotion and Protection Act*, *supra*, note 10 are not unwarranted. Although s.38 of the Act provides that "no person shall disclose to any other person the name of or any other information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease," there are a number of exceptions to this confidentiality provision. Disclosure is permitted if it "is made for the purposes of public health administration" [s.38(2)(c)] or "in connection with the administration of or a proceeding under this Act, the *Health Disciplines Act*, the *Public Hospitals Act*, the *Medical Care Act* (Canada), or the *Criminal Code* (Canada)" [s.38(2)(d)].

It is unclear what the scope of permissible disclosure is under the Act. The "purposes of public health administration" is a particularly broad and worrisome provision.

<sup>105</sup>*Narcotic Control Act*, R.S.C. 1985, c. N-1, s.3.

<sup>106</sup>In *R. v. Thorton* (1988), No. 157 SCC (Ottawa Registry File), a seropositive man was charged with common nuisance (s.176) after he donated blood to the Red Cross while fully aware of his HIV antibody status. See T. Ducharme, "Preparing for a Legal Epidemic", *supra*, note 6 at 490-4.

In the United States, numerous states have introduced legislation making the transmission of HIV a criminal offense. See Intergovernmental Health Policy Project- George Washington University, *A Synopsis of State AIDS Related Legislation (Through February 1988)* (Washington D.C.: The George Washington U., 1988) 31-39.

<sup>107</sup>This could constitute a violation of the right against self-incrimination under s.13 of the *Charter*. See P. Hogg, *Constitutional Law of Canada*, *supra*, note 63 at 781-783.

<sup>108</sup>Ontario, *Report of the Commission of Inquiry into the Confidentiality of Health Information* (Toronto: Queen's Printer, 1980) (Commissioner: H. Krever J.) [hereinafter *Krever Report*].

<sup>109</sup>See R. Gellman, "Prescribing Role of the Physician in the Protection of Patient Privacy" (1984) 62 N.C.L. Rev. 255 at 264-5.

<sup>110</sup>*Krever Report*, *supra*, note 108 at 73.

patient consent, also raises legitimate confidentiality concerns. The public health rationale of an active contact tracing program for HIV infection is questionable, given the costs involved and the likelihood that many contacts will be impossible to locate. As will be argued in Part III, a less invasive, limited contact tracing program is more effective and poses less of a risk of wide-spread disclosure. Although justified in some circumstances, particularly with regard to individuals unaware of their risk of exposure, even a limited contact tracing can present acute concerns about confidentiality. Although the identity of the index is not supposed to be released during contact tracing, in many circumstances, particularly in the case of couples in long term relationships, this measure will be entirely ineffective in protecting the identity of the index. In this context, contact tracing can result in serious prejudice — divorce or family separation being the most immediate and threatening possibilities — and it should only be performed where circumstances clearly warrant disclosure.

### *G. Opposition to Mandatory Reporting*

Despite the strict reporting requirements of the Act, there is opposition to and divergence from the Act in practice. As noted, in order to provide HIV tests to their patients without reporting the results to the government, Ontario physicians requesting an HIV test frequently provide only the initials of the patient on the request form. The laboratory report, a copy of which is sent to the Medical Officer of Health, would not include the name of the patient and the officer would be required to contact the physician directly in order to obtain this information. In addition, the Hassle-Free Clinic of Toronto offers strictly anonymous HIV antibody testing: patients are given a coded number when they come into the clinic for an HIV test; this number is attached to the test request form, and the patient later learns of the test results by providing his coded number. No records are kept by the Clinic which would indicate the identity of any person who was given a coded number.<sup>111</sup>

These practices, although to date largely tolerated by the Ministry of Health, plainly violate the reporting requirements under the *Health Promotion and Protection Act*, leaving the responsible physicians liable for prosecution under the Act.<sup>112</sup> A number of physicians in the Toronto area have not only refused to comply with the reporting requirements under the Act, but have also refused to comply with a direct order by the Medical Officer of Health that they reveal the names of their patients who are HIV sero-

<sup>111</sup>Telephone interview with Linda Gardner, counsellor at the Hassle-Free Clinic in Toronto (16 November 1988).

<sup>112</sup>Failure to comply with the reporting requirements of the Act is a violation of s.99(2), punishable by a fine of up to \$5,000 for every day the offense is continued [s.100].

positive. In an important test case, Dr A.S. Macpherson, the Medical Officer of Health for the City of Toronto, has issued a formal written order to a Toronto physician requesting that he release the name of a married bisexual patient who was HIV seropositive.<sup>113</sup> It is evident that the Ministry wants to inform the patient's wife of the risk of infection, but the doctor is of the opinion that contact tracing is unwarranted in the circumstances of his patient's case. The patient, fearing the destructive effect that information of his physical condition and sexual behavior could have upon his marriage, and the potential for HIV-related discrimination if this information is disclosed, is also challenging the Ministry's action.

As a result of this apparent shift in the policy of the Government of Ontario to prohibit anonymous HIV testing and strictly enforce the reporting requirements of the *Health Protection and Promotion Act* in order to perform contact tracing, the constitutionality and public health rationale of the mandatory reporting of HIV infection, a subject closely debated in the United States, is beginning to receive more attention from Canadian lawmakers and public health officials. For example, in 1986 an AIDS symposium held by the Ontario Medical Association came out in favour of anonymous HIV testing.<sup>114</sup> The following year, Dr Jim Henderson, Liberal M.P.P. for Humber, introduced a private member's bill in the Ontario legislature that would legalize anonymous testing.<sup>115</sup> If the Government of Ontario decides to proceed with its prosecution of physicians who refuse to cooperate with the mandatory reporting requirements presently in place, a constitutional challenge to the legislation is likely.

### III. Constitutional Analysis of Mandatory Reporting and Contact Tracing

Mandatory reporting raises at least two possible constitutional questions. First, does reporting violate privacy and, second, does it violate equality by prejudicially discriminating against the physically disabled? Both privacy and equality rights are in their infancy in terms of the development of Canadian constitutional doctrine and, as in many matters of novel *Charter* jurisprudence, American precedent has proven a useful aid. In particular, the American Courts, given their now extensive experience with the AIDS epidemic (and their ever-litigious nature), have developed a substantial body of anti-discrimination law of critical importance to AIDS-related legal questions. The following discussion, which primarily focusses on an equality analysis of mandatory reporting, finds its base in these American

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<sup>113</sup>"Doctor Ordered to Reveal Name of Patient in AIDS Test" *The [Toronto] Globe and Mail* (20 May 1988) A14.

<sup>114</sup>"Identifying AIDS patients rejected" *The [Toronto] Globe and Mail* (13 June 1986).

<sup>115</sup>Press Release (30 November 1987). "Toronto MPP's Bill Would Legalize Anonymous Testing for AIDS Virus" *The Toronto Star* (13 December 1987) A20.

precedents and presents the argument that these precedents provide fertile ground for addressing the constitutional and public health consequences of mandatory reporting in Canada.

### A. *Equal Protection under the American Constitution*

The constitutional implications of mandatory reporting of HIV infection have been extensively reviewed by scholars in the United States.<sup>116</sup> The Fourteenth Amendment provides that “[n]o State shall make or enforce any law which shall ... deny to any person within its jurisdiction the equal protection of the laws.”<sup>117</sup> Under equal protection analysis in American law, before any substantive constitutional review of mandatory reporting is possible, a “suspect class” or a “fundamental right” which is adversely affected by mandatory reporting must first be identified.

#### 1. HIV Disease as a Suspect Class

In equal protection analysis, only legislative classifications which touch on suspect classes, such as race or national origin,<sup>118</sup> are closely reviewed by the courts under the doctrine of “strict scrutiny”. Laws which do not touch on these interests are only subject to minimal judicial examination, often referred to as the “mere rationality” test, a level of scrutiny which rarely results in any judicial intervention.

The United States Supreme Court has also created a new, intermediate level of review where the Court applies heightened scrutiny to sensitive or “quasi-suspect” classifications, notably gender,<sup>119</sup> alienage,<sup>120</sup> and illegitimacy.<sup>121</sup> Nonetheless, the Court has been careful to limit the categories of suspect and quasi-suspect classes and fundamental rights;<sup>122</sup> most impor-

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<sup>116</sup>For articles addressing the constitutional implications of mandatory reporting schemes in the United States, see D. Costa, “Reportability of Exposure to the AIDS Virus: An Equal Protection Analysis” (1986) 7 *Cardozo L. Rev.* 1103; D.J. Merritt, “Communicable Disease and Constitutional Law: Controlling AIDS” (1986) 61 *N.Y.U.L. Rev.* 739; L. Orland & S.L. Wise, “The AIDS Epidemic: A Constitutional Conundrum” (1985) 14 *Hofstra L. Rev.* 137; W. Curran, L. Gostin, & M. Clark, *Acquired Immunodeficiency Syndrome: Legal and Regulatory Policy* (Boston: Harvard School of Public Health, 1986) at 242-273; and M. Barnes, “Confidentiality”, in A. Rubinfeld, ed., *AIDS Legal Guide*, *supra*, note 4 at 4-1.

<sup>117</sup>U.S. Const. amend. XIV, s. 1.

<sup>118</sup>See, e.g., *Loving v. Virginia*, 388 U.S. 1 (1967).

<sup>119</sup>See, e.g., *Craig v. Boren*, 429 U.S. 190 (1976).

<sup>120</sup>See, e.g., *In re Griffiths*, 413 U.S. 717 (1973).

<sup>121</sup>See, e.g., *Trimble v. Gordon*, 430 U.S. 762 (1977).

<sup>122</sup>For example, the Court has refused to extend heightened treatment to classifications based on age or wealth. See, e.g., *Massachusetts Bd. of Retirement v. Murgia*, 427 U.S. 307 (1976) (age is not a suspect class); *San Antonio Indep. School Dist. v. Rodriguez*, 411 U.S. 1 (1973) (wealth is not a suspect classification nor is education a fundamental right).

tantly, for reasons discussed below, it seems unlikely that any of these categories could be extended to encompass the interests affected by a state mandatory reporting and contact tracing program.

Those in favour of substantive constitutional review have argued that legislation which classifies individuals on the basis of HIV infection creates a suspect class which should be subject to heightened or strict scrutiny by the courts.<sup>123</sup> There are generally four elements characteristic of suspect classes: a history of discrimination, stigmatization, immutability and political powerlessness.<sup>124</sup> HIV disease could create a suspect class, given that there is no question that seropositive individuals have been subject to wide-ranging discrimination in employment, education, housing, insurance, and medical treatment. The stigmatization suffered by those with HIV disease, an immutable condition, has already been described in detail. The relative political powerlessness of people infected with a contagious and widely feared disease, particularly when those at the greatest risk of infection are already members of disadvantaged and disfavoured groups (in the U.S., primarily black and Hispanic IV drug users, and gay men), is also a compelling reason for judicial scrutiny.<sup>125</sup>

The argument, however, is problematic. First, the Fourteenth Amendment has not generally been successfully invoked to challenge public health measures designed to control communicable disease. Although the protection of individual rights and our knowledge of disease has considerably expanded since these cases were decided, several courts in the past have held that health regulations enacted by the state under its police power are not generally reviewable under the provisions of the Fourteenth Amendment: the courts are unwilling to create a situation where "... a state would be rendered powerless to protect itself by prompt and speedy action from the spread of contagion."<sup>126</sup>

More importantly, the Supreme Court has expressly refused to extend suspect classification to physically or mentally disabled individuals. In *City*

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<sup>123</sup>D. Costa, "Reportability of Exposure to the AIDS Virus: An Equal Protection Analysis", *supra*, note 116 at 1118-23.

<sup>124</sup>L.H. Tribe, *American Constitutional Law*, 2d ed. (Mineola, N.Y.: Foundation Press, 1988) at 1052-53, ss. 16-22.

<sup>125</sup>L. Orland & S.L. Wise, "The AIDS Epidemic: A Constitutional Conundrum", *supra*, note 116 at 139-43.

<sup>126</sup>*Ex parte Caselli*, 62 Mont. 201, 204 P. 364 at 364 (1922). See also *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) where the Court upheld a Cambridge ordinance requiring mass public vaccination to prevent the spread of an epidemic. These cases were, however, decided before the 1960s and 1970s during which the American courts expanded constitutional civil rights much more aggressively. They may no longer be particularly controlling precedents.

of *Cleburne, Tex. v. Cleburne Living Center*,<sup>127</sup> the Court held that mentally handicapped individuals did not constitute either a suspect or a quasi-suspect class. The Court concluded that "if the large and amorphous class of the mentally retarded were deemed quasi-suspect ... it would be difficult to find a principled way to distinguish a variety of other groups who have perhaps immutable disabilities setting them off from others ... . One need mention in this respect only the aging, the disabled, the mentally ill, and the infirm."<sup>128</sup> The refusal of the Court to extend protection to the disabled and the infirm precludes any argument that discrimination on the grounds of a physical disability, such as HIV infection, could give rise to an equal protection challenge.

Finally, the intersection between homosexual activity and HIV infection is unlikely to encourage the courts to abandon their established reluctance and expand the suspect classes to include those who are seropositive. Gay people have not been recognized as a suspect class under equal protection doctrine,<sup>129</sup> nor has the right to privacy ever been extended to include consensual, adult sodomy.<sup>130</sup> Moreover, such an argument may be counter-productive. As earlier pointed out, AIDS is not a gay disease; stressing the intersection between homosexuality and AIDS only increases the stigmatization surrounding AIDS. Given the reluctance of the American courts to expand the categories of suspect or quasi-suspect classes, it is unlikely that individuals adversely affected by an HIV mandatory reporting scheme could be characterized as a suspect class.

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<sup>127</sup>473 U.S. 432 (1985) [hereinafter *Cleburne*]. Although the Court did not find that the mentally handicapped formed a suspect class, the Court nonetheless found that the impugned legislation did not even meet the "rationally related" standard of minimal scrutiny [at 447-50]. This raises the intriguing possibility that the Court has decided in certain cases that even where there is no suspect class affected, the legislation may nonetheless be subject to some heightened scrutiny. The traditional rational basis test, prior to *Cleburne*, was a far more predictably deferential level of review. This development, only now in its infancy in American law, may in the future provide some judicial protection to non-suspect classes, such as physical disability. See D.J. Merritt, "Communicable Disease and Constitutional Law: Controlling AIDS", *supra*, note 116 at 784-98.

<sup>128</sup>*Ibid.* at 445-6.

<sup>129</sup>*DeSantis v. Pacific Tel. & Tel. Co. Inc.*, 608 F.2d 327 at 333 (9th Cir. 1979) which held that homosexuals have not been designated a "suspect" or "quasi-suspect" class requiring stricter scrutiny of classifications on the basis of homosexuality. But see *Watkins v. United States Army*, 837 F.2d 1428 (9th Cir. 1988) which recently held that homosexuals constitute a suspect class and that Army regulations that discriminate on the basis of homosexual orientation are unconstitutional. This decision was, however, subsequently withdrawn by an eleven judge *en banc* panel of the Ninth Circuit Court of Appeals in a decision in which the majority of the panel did not address the equal protection issue raised in the previous decision. *Watkins v. United States Army*, No. 85-4006 (3 May 1989)[unreported].

<sup>130</sup>*Bowers v. Hardwick*, 106 S. Ct. 2841 (1986) [hereinafter *Bowers*]. See the discussion, *infra*, note 143 ff. and accompanying text.

## 2. Mandatory Reporting and Privacy

Heightened scrutiny might still be available if it can be shown that the mandatory reporting of HIV infection interferes with some fundamental right protected under the Constitution. A number of these fundamental rights which fall under the equal protection clause have been identified, and they include such interests as the right to vote,<sup>131</sup> the right to travel interstate,<sup>132</sup> and the right to privacy.<sup>133</sup> One aspect of the right to privacy is the right to informational privacy and this could have important consequences for the mandatory reporting of HIV infection.<sup>134</sup>

In *Whalen v. Roe*,<sup>135</sup> the Supreme Court held that a New York statute requiring reports by name and address of persons obtaining abusable prescription drugs did not pose a sufficiently grievous threat to individual privacy interests to establish a constitutional violation.<sup>136</sup> The patients argued that the misuse of this data would cause them to be stigmatized as drug addicts but the state defended the collection of the data as a means to control the illegal use of dangerous drugs.<sup>137</sup> The Court held that:

disclosure of private medical information to doctors, to hospital personnel, to insurance companies, and to public health agencies are [sic] often an essential part of modern medical practice even when the disclosure may reflect unfavorably on the character of the patient. Requiring such disclosures to representatives of the State having responsibility for the health of the community, does not automatically amount to an impermissible invasion of privacy.<sup>138</sup>

The Court added that the statutory reporting of venereal disease was a "familiar example" of such required disclosure.<sup>139</sup> Although the regulation was upheld, the Court suggested that there were constitutional limitations on the government's power to collect information about its citizenry. The

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<sup>131</sup>See, e.g., *Harper v. Virginia Bd. of Elections*, 383 U.S. 663 (1966).

<sup>132</sup>See, e.g., *Griffin v. Illinois*, 351 U.S. 12 (1956).

<sup>133</sup>See e.g., *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (right to privacy extended to include the use of contraceptives by unmarried persons); and *Roe v. Wade*, 410 U.S. 113 (1973) (right to privacy includes a women's interest in terminating pregnancy).

<sup>134</sup>See generally D. Costa, "Reportability", *supra*, note 116 at 1124-28, and Note, "Contact Tracing for HIV Infection: A Plea for Privacy" (1989) Colum. Hu. Rts. L. Rev. [forthcoming] See also W. Parmet, "Public Health Protection and the Privacy of Medical Records" (1981) 16 Harv. C.R.-C.L. L. Rev. 265 at 294-98 (discussion of *Whalen*); and W. Winslade, "Confidentiality of Medical Records: An Overlook of Concepts and Legal Policies" (1982) 3 J. Legal Med. 497 at 518.

<sup>135</sup>429 U.S. 589 (1977).

<sup>136</sup>*Ibid.* at 600.

<sup>137</sup>*Ibid.* at 595.

<sup>138</sup>*Ibid.* at 602.

<sup>139</sup>*Ibid.* at 602 n.29.

Court was confident, however, that the security provisions in the statute were adequate to prevent any unwarranted disclosure.<sup>140</sup>

Although the decision in *Whalen* found no violation of informational privacy, it does not necessarily preclude any challenge to the mandatory reporting of HIV infection.<sup>141</sup> The State may be able to present a far less convincing argument in defense of the mandatory reporting of HIV infection given the limited epidemiological significance of this information.<sup>142</sup> Further, contact tracing in effect necessitates the disclosure of highly sensitive information, unlike the statutory scheme in *Whalen* under which disclosure was strictly limited. Given the significantly more invasive nature of this practice, the constitutional review of HIV reporting and contact tracing might be more stringent than that illustrated in *Whalen*.

In a related decision, *Bowers v. Hardwick*,<sup>143</sup> a sharply divided Supreme Court held that the constitutional right to privacy did not extend to private consensual homosexual sodomy.<sup>144</sup> Although this decision did not address the issue of informational privacy, *Bowers* does illustrate the reluctance of the Court to expand the privacy guarantees under the Constitution. Even more marked in *Bowers* is the pronounced judicial hostility to the rights of gay people.<sup>145</sup> Although the mandatory reporting of HIV infection affects a far broader class than gay people, it is clear that the hostility expressed in *Bowers*, both towards gay people in particular and the right to privacy in general, does not point in the direction of judicial sympathy for the interests affected in the mandatory reporting of HIV infection.

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<sup>140</sup>*Ibid.* at 601. So long as statutory or regulatory safeguards give only authorized officials access to the information, the reporting requirement is likely to be held constitutional. See W. Parmet, "Public Health Protection and the Privacy of Medical Records", *supra*, note 134 at 294.

<sup>141</sup>See L. Gostin, M. Clark & W. Curran, "AIDS: Legal and Policy Implications of the Application of Traditional Disease Control Measures" in L. Gostin & W. Curran, eds, "AIDS: Law and Policy" (1987) 15 *Law, Medicine and Health Care* 27 [hereinafter "AIDS: Legal and Policy Implications"] at 28-31 and M. Barnes, "Confidentiality", *supra*, note 116 at 4-1, 4-5.

<sup>142</sup>See the discussion below in Part III D.

<sup>143</sup>*Bowers*, *supra*, note 130.

<sup>144</sup>*Bowers* has produced a flood of law review articles, all uniformly deploring the position taken by the Supreme Court and arguing that the decision is not consistent with privacy jurisprudence in the United States. See e.g.: M. Kohler, "History, Homosexuals, and Homophobia: The Judicial Intolerance of *Bowers v. Hardwick*" (1986) 19 *Conn. L. Rev.* 129; C. Ferree, "*Bowers v. Hardwick*: The Supreme Court Closes the Door on the Right to Privacy and Opens the Door to the Bedroom" (1988) 64 *Denver U.L. Rev.* 599; M. Siderides, "*Bowers v. Hardwick*: The Invasion of Homosexuals' Right of Privacy" (1987) 8 *Bridgeport L. Rev.* 229; and T. Stoddard, "Essay: *Bowers v. Hardwick*: Precedent by Personal Predilection" (1986) 54 *U. Chi. L. Rev.* 1129.

<sup>145</sup>Chief Justice Burger was, in particular, impressed by the long standing condemnation of homosexual practices: "proscriptions against sodomy... [are]... firmly rooted in Judaeo-Christian moral and ethical standards." *Bowers*, *supra*, note 130 at 2847.

Because seropositive individuals are unlikely to form a suspect class under the American equal protection provisions, heightened scrutiny of a mandatory reporting scheme would more likely take place on the grounds of informational privacy. The development of this privacy right is, however, as yet too uncertain to predict with confidence that the courts would extensively review a mandatory reporting scheme under this doctrine. Interestingly, the situation is exactly the reverse under Canadian constitutional law: rather than an argument based on informational privacy, a much more compelling argument can be made that seropositive individuals constitute what is roughly the equivalent to a "suspect" class under s. 15 of the *Charter*.

### 3. The American Constitutional Analysis of HIV Disease and the *Charter*

The analysis of HIV disease under the American *Constitution* can be distinguished from the *Charter* for a variety of reasons. First, although American case law on informational privacy might provide the most promising basis for challenging a mandatory reporting scheme in the United States, it is unlikely that these precedents would be useful in Canada because, unlike the American *Constitution*, the guarantees in the *Charter* have not yet been interpreted as including a right to privacy.<sup>146</sup> In particular, American precedents relating to informational privacy are unlikely to apply to *Charter* challenges. For example, in *Charboneau v. College of Physicians and Surgeons of Ontario*, the Ontario High Court held that the inspection of patient records, allegedly infringing a patient's right to confidentiality,

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<sup>146</sup>It is possible that the right to privacy in the United States may have some bearing on the interpretation of s.7 of the *Charter* which 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." In *R. v. Morgentaler*, [1988] 1 S.C.R. 30, where the Court held that restricted access to abortion constitutes a breach of security of the person, the Court expressly declined to consider whether the right to security of the person extended further to protect "either interests central to personal autonomy, such as a right to privacy, or interests unrelated to criminal justice." A compelling argument can be made that a mandatory HIV reporting scheme also infringes on security of the person. Mandatory reporting discourages individuals from taking HIV tests and ignorance of their HIV status places them at a greater health risk, particularly as some treatments for HIV infection are now becoming available. Ignorance of their status also places their sexual partners at an extremely high risk of becoming infected. Much as the denial of access to abortions constitutes a violation of security of the person, denial of adequate and confidential health care for individuals infected with HIV may as well violate s.7.

Rather than develop a s.7 argument, this paper will examine s.15 for two reasons. First, an adequate examination of the s.7 implications of a mandatory reporting scheme is properly the subject of a separate paper. Second, a more compelling, and less complex, argument can be made that HIV infection constitutes a physical disability under s.15.

does not violate s. 7 (security of the person) or s. 8 (unreasonable search and seizure) in the *Charter*.<sup>147</sup>

Although American case law on informational privacy may not be well received by the Canadian courts, it is important to point out that the less impressive aspects of American privacy and equality jurisprudence, which reveal a disturbing judicial and legislative hostility towards gay people, have also not found fertile ground in Canada. For example, the question raised in *Bowers* has been settled by legislative reform; sodomy between consenting persons twenty-one years or older was decriminalized in Canada in 1969.<sup>148</sup> Moreover, although the question has yet to be examined by the courts, numerous authors have argued that homosexuals are a protected class under s. 15 of the *Charter*; the American precedents which refuse to extend equal protection to homosexuals may bear little relation to the *Charter*.<sup>149</sup> Finally, discrimination on the basis of sexual orientation is prohibited in the Human Rights statutes in Ontario, Quebec, Manitoba and the Yukon.<sup>150</sup>

The more important issue, and one unrelated to the legal status of gay people, is whether seropositive individuals enjoy any particular constitutional protection. This question takes on an entirely different perspective in Canada because the *Charter*, unlike the American *Constitution*, extends equal protection to the physically disabled. In *Cleburne*<sup>151</sup> the American Supreme Court specifically declined to apply equal protection analysis to the physically disabled, but the *Charter* expressly includes this class of individuals under the equality provisions in s. 15. If HIV disease is held a physical disability under s. 15 of the *Charter*, the complex and difficult task

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<sup>147</sup>In *Charboneau v. College of Physicians and Surgeons of Ontario* (1985), 22 D.L.R. (4th) 303 (Ont. H.C.), the High Court considered whether the provisions of the *Health Disciplines Act*, R.S.O. 1980, c. 196 which provided for random peer assessment of doctors practices and permitted assessors to inspect confidential patient records, violated the patient's right to security of the person or constituted an unreasonable search and seizure. The Court held that security of the person does not entail a right to privacy and that even if s.7 does provide some patient right to confidentiality, this right is qualified and subject to valid legal requirements [at 309]. The interest of maintaining acceptable standards of medical competence was sufficient to justify the inspection of patient records [at 311]. The Court also held that the requirement to produce patient records did not constitute an unreasonable search and seizure because the assessor had no power to seize the records [at 313].

<sup>148</sup>*Criminal Code*, R.S.C. 1970, c. C-34, s.158.

<sup>149</sup>See J.E. Jefferson, "Gay Rights and the Charter" (1985) 43 U.T. Fac. L.Rev. 70; N. Duple, "Homosexualité et droits à l'égalité dans les Chartes canadienne et québécoise" (1984) 25 C. de D. 801; A. Bruner, "Sexual Orientation and Equality Rights" in A.F. Bayefsky & M. Eberts, eds, *Equality Rights and the Canadian Charter of Rights and Freedoms* (Agincourt, Ont.: Carswell, 1985) at 457.

<sup>150</sup>See e.g., S.O. 1981, c. 53 as am.

<sup>151</sup>See *Cleburne*, *supra*, note 127 and accompanying discussion.

of identifying a constitutionally protected interest is more easily realized under Canadian than American constitutional law.

**B. The Charter: Is HIV Disease a Physical Disability Under s. 15?**

Although most human rights legislation in Canada has provided protection for the physically disabled for over ten years,<sup>152</sup> and s. 15 of the *Charter* provides that "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination ... based on ... physical disability", the content of this legislative and constitutional protection has not been extensively explored by the courts. In particular, it is not yet clear whether protection for the physically disabled extends to those who suffer from an infectious illness.<sup>153</sup>

The mandatory reporting of HIV infection affects two somewhat different classes of individuals: those who are asymptotically infected with HIV and have not yet developed any life-threatening symptoms, and those whose HIV infection has progressed to the point where they are susceptible to opportunistic infections which could be life-threatening. It is this second condition that is commonly called AIDS, although it is important to emphasise that the sharp line typically drawn between asymptomatic HIV infection and AIDS is becoming increasingly blurred. As recent medical evidence indicates, HIV disease is a progressive condition and most, if not all, HIV-infected individuals will at some point develop some symptoms of HIV disease.<sup>154</sup> Accepting for the moment this increasingly artificial distinction, the question of whether both AIDS and asymptomatic HIV infec-

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<sup>152</sup>W.S. Tarnopolsky, *Discrimination and the Law*, rev'd ed. by W. Pentney (Toronto: DeBoo, 1985) 9-15. Although the mandatory reporting of HIV infection could theoretically be challenged under the provisions of the *Ontario Human Rights Code*, *supra*, note 150, which prohibits discrimination on the basis of a handicap [s.1 and s.9(b)] and provides that the provisions of the *Code* "prevail" over legislation in contravention of the *Code* [s.46(2)], I have chosen to consider primarily the provisions of the *Charter*.

First, although the *Code* takes primacy over other pieces of legislation, courts have only rarely invalidated legislation because it conflicts with human rights legislation. See, e.g., *Re Winnipeg School Division No. 1 v. Craton*, [1985] 2 S.C.R. 150. See generally, *Discrimination and the Law*, *ibid.*, Cum. Supp. at 60-61. Further, any "clear legislative pronouncement" is sufficient to override the Human Rights Code; the provisions of the *Ontario Health Promotion and Protection Act* are likely sufficient. In contrast, the "notwithstanding" provision of s.33 of the *Charter* seems to require a more express statement by the legislature in order to override a *Charter* guarantee. Most importantly, the human rights codes have not been interpreted by the courts as requiring them to scrutinize legislation; unlike the *Charter*, human rights codes are directed primarily at private acts of discrimination, not the review of legislation.

<sup>153</sup>Only one Canadian decision has addressed this issue, *Biggs v. Hudson*. See discussion beginning at *infra*, note 173 and accompanying text.

<sup>154</sup>See *supra*, note 3.

tion are physical disabilities under the *Charter* will turn on two central issues. First, can a contagious illness, such as AIDS or asymptomatic HIV infection, constitute a physical disability and second, is a contagious illness such as asymptomatic HIV infection, which exhibits only limited physical impairment, a physical disability?

1. American Precedent on Physical Disability, Infectious Diseases, and HIV

Given the minimal Canadian precedent on the question of whether a contagious disease such as HIV infection is a physical disability under human rights legislation or s. 15 of the *Charter*, it is helpful to consider first the now extensive American precedent related to this issue. In *School Board v. Arline*,<sup>155</sup> the United States Supreme Court addressed the issue of whether a person who suffers from an infectious and communicable disease, in this case tuberculosis, was protected under the *Rehabilitation Act of 1973* which prohibits discrimination on the basis of a physical handicap.<sup>156</sup> The Court held that a person afflicted with tuberculosis was a "handicapped individual" within the meaning of the Act.<sup>157</sup> The Court stated that if Arline could establish that despite her condition she was "otherwise qualified" within the meaning of the Act, she could be reinstated in her job as a public elementary school teacher: "the fact that a person with a record of a physical impairment is also contagious does not suffice to remove that person from coverage under [the Act]."<sup>158</sup>

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<sup>155</sup>480 U.S. 273, 94 L.Ed. 2d 307, 107 S. Ct. 1123 (1987) [hereinafter *Arline* cited to S. Ct.]. Numerous articles examining *Arline* have been published, many of which consider whether AIDS is also a covered handicap under the Federal *Rehabilitation Act of 1973*, Pub. L. No. 93-112, 87 Stat. 357 (codified as amended at 29 U.S.C. s. 701-96 (1982)) [hereinafter *Rehabilitation Act*]. See, e.g., R. Wasson, "AIDS Discrimination under Federal, State, and Local Law after *Arline*" (1987) 15 Fla. St. U.L. Rev. 221; R. Lipshutz, "Arline: Real Protection Against Discrimination for Society's New Outcasts?" (1988) 27 Stetson L. Rev. 517; J. Leader, "Running From Fear Itself: Analyzing Employment Discrimination Against Person with AIDS and other Communicable Diseases under Section 504 of the Rehabilitation Act of 1973" (1987) 23 Willamette L. Rev. 857; L. Farley, "AIDS and Employment Discrimination: Employer Guidelines and Defenses — *School Board of Nassau County, Florida v. Arline*" (1988) 23 Wake Forest L. Rev. 305.

<sup>156</sup>*Rehabilitation Act, ibid.* Prior to *Arline*, only one other court had dealt with the issue of whether the Act extended protection to individuals with a contagious disease: *New York Assoc. for Retarded Children v. Carey*, 612 F.2d 644 (2d Cir. 1979). Here the court held that children who suffered from serum hepatitis B, a contagious disease, could not be excluded from regular classrooms unless the School Board could demonstrate that these children presented a health hazard to those around them.

<sup>157</sup>*Arline, supra*, note 155 at 1127.

<sup>158</sup>*Ibid.* at 1130-31. The case was remanded to the District Court to determine whether Arline was otherwise qualified for her position, that is, whether her contagious condition presented a significant health and safety risk to others.

Although the Court expressly declined to address the issue of whether HIV infection could constitute a physical handicap under the Act,<sup>159</sup> subsequent decisions of lower courts have extended the application of the Act to both individuals who have developed AIDS and those who have asymptomatic HIV infection. In *Chalk v. United States District Court*, the Ninth Circuit Court of Appeals held that Chalk, a teacher of hearing-impaired students who was diagnosed with AIDS, was entitled to protection under the Federal *Rehabilitation Act*, citing *Arline* as authority for the proposition that the Act is fully applicable to individuals who suffer from contagious diseases.<sup>160</sup> *Doe v. Centinela Hospital*, a recent decision of a California District Court, held that individuals who are HIV infected and have not developed AIDS are also protected under the Act because they are perceived as having a disabling handicap, regardless of the extent of their actual physical disability.<sup>161</sup> Citing *Arline*, the Court concluded that "discrimination based solely on fear of contagion is discrimination based on a handicap."<sup>162</sup>

The U.S. Federal Justice Department has also recently issued a legal opinion affirming that individuals who are HIV-infected are covered by the *Rehabilitation Act*.<sup>163</sup> This opinion reversed the Department's earlier interpretation of the Act to the effect that although AIDS produced disabling effects and was thus a handicap under the Act, asymptomatic HIV infection did not qualify as a handicap because there was no physical impairment.<sup>164</sup> The Department had argued that the ability to transmit disease, absent any disabling aspects of disease, was not a handicap under the Act and that discrimination based on the fear of contagion was not prohibited by the Act. The recent Department opinion entirely abandons this argument and brings the Justice Department's official policy in line with *Arline* and its progeny.

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<sup>159</sup>*Ibid.* at 1128 n.7.

<sup>160</sup>*Chalk v. United States District Court Central District of California*, 840 F.2d 701, (9th Cir. 1988). See also *Doe v. Dolton Elementary School District*, DC NIII, EDiv, No. 87 C 8713 (23 June 1988) reported in *AIDS Policy and Law*, vol. 3, No. 14, (27 July 1988) (which held that a student with AIDS "is likely to be considered a handicapped individual" under the *Rehabilitation Act*, citing *Arline* as authority).

<sup>161</sup>*Doe v. Centinela Hospital*, DC CCalif., No. CV 87-2514 PAR (PX) (30 June 88) also reported in *AIDS Policy and Law*, vol. 3, No. 13, (13 July 1988).

<sup>162</sup>*Doe v. Centinela Hospital*, *ibid.* at 12.

<sup>163</sup>Lambda Legal Defense and Education Fund, *AIDS Update*, vol.3, No.3. (November 1988) at 2. The Justice Department concluded that HIV infection, even if asymptomatic, limits one's ability to procreate and engage in sexual activity, thus constituting a physical disability. The memorandum also noted that the negative reaction of others is a further limitation suffered by seropositive individuals.

<sup>164</sup>See L. Farley, "Employment Discrimination — AIDS" (1988) 23 Wake Forest L. Rev. 305 at 320, which discusses this 1986 United States Department of Justice Memorandum.

The inclusion of both asymptomatic HIV infection and AIDS under the definition of a physical handicap in American case law may become an important precedent for the development of both human rights and *Charter* jurisprudence in Canada. The inclusion of a contagious disease as a physical disability, whether or not there is some physical manifestation of impairment, represents a critical evolution in the law.

*Arline*, however, only considers the scope of remedies afforded by federal legislation under the *Rehabilitation Act* and does not address possible constitutional remedies, likely because none are available under American law. As noted above, the physically handicapped do not form a suspect class under American equal rights case law. The decision in *Arline* thus has little constitutional significance in American law and could not be used in the United States as a basis on which to challenge an HIV mandatory reporting and contact tracing program. Because the *Charter* expressly includes the physically disabled under s. 15, however, the significance of *Arline* as a persuasive precedent in Canada is not confined exclusively to human rights legislation. *Arline* may prove even more useful as a precedent to aid in the development of a unique Canadian constitutional jurisprudence that provides equality protection for the interests of the physically disabled.

## 2. HIV Disease and Physical Disability under the *Charter*

Because the *Charter* provides no definition of physical disability, it is fair to assume that as a first step the courts would consider the various definitions of physical disability that are provided in related human rights legislation. For example, as considered in *Arline*, the American *Rehabilitation Act of 1973* defines a handicapped individual as "any person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment."<sup>165</sup> The regulations promulgated by the Department of Health and Human Services further define "physical impairment" as "any physiological disorder or condition ... affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; cardiovascular; reproductive digestive, genito-urinary; hemic and lymphatic; skin; and endocrine."<sup>166</sup> In addition, the regulations define "major life activities" as "functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."<sup>167</sup>

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<sup>165</sup>29 U.S.C. § 706(7)(B).

<sup>166</sup>45 CFR § 84.3(j)(2)(i) (1985).

<sup>167</sup>45 CFR § 84.3(j)(2)(ii) (1985).

The definition of handicapped under the *Rehabilitation Act* is similar to that of the Ontario *Human Rights Code* which defines a handicapped person as one who "has or has had, or is believed to have or have had, (i) any degree of physical disability ... that is caused by ... illness and, without limiting the generality of the foregoing, including diabetes mellitus, epilepsy, any degree of paralysis, amputation, lack of physical coordination ..."<sup>168</sup> Significantly, both the American and Ontario provisions provide protection for those who are perceived to have a handicap, whether or not they are in fact handicapped. The Ontario *Code* also expressly refers to disabilities caused by illness whereas the American provision more generally refers to physical impairments which limit a person's major life activities.

In human rights legislation across Canada, "physical disability" has been interpreted as providing protection to individuals who suffer the disabling effects of bodily injury, disease, or congenital deformity. Physical conditions caused by accidents,<sup>169</sup> asthma,<sup>170</sup> speech impediments,<sup>171</sup> hypertension and high blood pressure,<sup>172</sup> have been held to be physical disabilities. These cases illustrate that "disability" has not been confined to medical conditions with immediately apparent symptoms, such as the obvious impairment suffered by someone in a wheelchair, but has been interpreted as including medical conditions that have no manifest symptoms, such as hypertension. There can thus be no question that nonapparent physical conditions resulting from an illness can constitute a physical disability, and this has obvious significance for people with HIV disease.

Consistent with this body of law governing the definition of physical disability is the recent decision of the British Columbia Human Rights Tribunal in *Biggs v. Hudson*, the first Canadian decision addressing the question of whether protection for the physically disabled extends to people with AIDS, where it was held that all aspects of HIV disease, including the period of asymptomatic infection, constitute a physical disability under the *B.C. Human Rights Act*.<sup>173</sup> In *Biggs*, the Tribunal went even further to hold

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<sup>168</sup>*Supra*, note 150, s. 9(1)(b).

<sup>169</sup>*Commission des Droits de la Personne v. Ville de Laval* (1983), (1984) 5 C.H.R.R. D/1819 (S.C.).

<sup>170</sup>*Legge v. Princess Auto and Machinery Ltd* (1983), 4 C.H.R.R. D/1339.

<sup>171</sup>*Matlock v. Canora Holdings Ltd* (1983), 4 C.H.R.R. D/1576.

<sup>172</sup>*Wamboldt v. Dept. of National Defence* (1983), 4 C.H.R.R. D/1479.

<sup>173</sup>*Biggs v. Hudson* (1988), 9 C.H.R.R. D/5391 is the first Canadian decision dealing with AIDS as a physical disability, decided pursuant to s. 5 of the *B.C. Human Rights Act* S.B.C. 1984, c. 22 which 5 prohibits discrimination in housing on the basis of a "physical or mental disability". See also P. Bryden and B. Jarrett, "AIDS, Employment Discrimination and the B.C. Human Rights Act" (1988) 9 C.H.R.R. 7. In *Biggs*, the tribunal held that AIDS "constitutes a physical disability within the meaning of the Act" and that "any person who is seropositive

that individuals who suffer discrimination because they are perceived as being members of a class of persons who are at a higher risk of HIV infection, such as homosexuals or IV drug users, are also entitled to protection under the Act.<sup>174</sup> Although the question has not yet been addressed by a board of inquiry under the Ontario *Human Rights Code*, it is also the official policy of the Ontario Human Rights Commission that AIDS is a physical disability under s. 9(1)(b) of the *Code*.<sup>175</sup> The courts have yet to examine the physical disability provision under s. 15 of the *Charter*; however, it can be expected that they will carefully examine the precedents in *Biggs* and *Arline* and may find their reasoning persuasive.<sup>176</sup>

Given the extreme consequences of an advanced HIV infection that has progressed to AIDS, an obvious case can be made that AIDS is a disease that causes a significant degree of physical disability and thus falls squarely within the scope of not only the related human right's provisions, but the

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by manifesting antibodies to HIV has a physical disability" [at 12].

Prior to the B.C. decision, there was also one Canadian labour arbitration case which addressed the issue of AIDS in the employment context: *Pacific Western Airlines Ltd. v. Canadian Air Line Flight Attendants Assoc.* (16 April 1987) (B.C. Labor Arbitration). The tribunal held that a flight attendant who had been suspended with pay because it was suspected he had contacted AIDS constituted a breach of the collective agreement because the employer had "failed to establish that there is any risk that an employee with AIDS will transmit it to fellow employees or passengers" [at 3].

<sup>174</sup>The tribunal held "that any person who belongs to groups widely regarded as especially vulnerable to HIV infection but who are (sic) not HIV infected or whose HIV status is unknown ("high risk groups"), are protected under the term "physical disability" in the Act" (at 16). The tribunal thus extended the protection for the disabled to all IV drug users and homosexuals, as groups who may be subject to discrimination "because of a perception or impression that the person or classes of persons would be a carrier or transmitter of HIV" (at 16).

<sup>175</sup>Ontario Human Rights Commission, *Annual Report 1985-86* at 33; see also, Ontario Human Rights Commission, *Policy Statement on HIV/AIDS-Related Discrimination*, pre-publication version (June 1989), where the Commission states that "all persons infected with HIV a HIV-related illness, including those who are asymptomatic, are entitled to the full protection..." of the Human Rights Code. According to the Commissioner, the Code also prohibits discrimination against groups "who are believed to be a high risk or carriers of HIV." The Code's explicit prohibition of discrimination on the ground of sexual orientation provides further protection to gay men who are perceived as being at high risk.

For an examination of whether the physical disability provisions in Canadian human rights legislation include contagious illnesses such as AIDS, see J. Kenney, "AIDS in the Workplace: Termination, Discrimination and the Right to Refuse" (1987) *Dalhousie L. J.* 581, at 599-602. After examining the *Arline*, the author concludes that there "is nothing in the Canadian human rights legislation that would prevent a wide interpretation of handicap from being made, thereby offering protection to person with communicable diseases and AIDS." [at 601.]

<sup>176</sup>The Supreme Court has not yet considered the physical disability provisions in s.15 of the *Charter*. In *E. Mrs. v. Eve*, [1986] 2 S.C.R. 388 at 436-7, the Supreme Court did, however, address the issue of mental disability. The Court briefly considered whether the equality rights of the mentally disabled were violated if the government could not act on their behalf to obtain a non-therapeutic sterilization. The Court found no such violation.

*Charter* as well. However, two questions remain: first, whether HIV disease can be distinguished from other illnesses because it is infectious, and second, whether asymptomatic HIV infection constitutes a physical disability.

(a) *An Infectious Disease as a Physical Disability*

The Court in *Arline* refused to accept that an infectious disease should be distinguished from other illnesses causing a physical disability. The School Board had argued that Arline had been dismissed not because of her physical impairment but because of the threat of contagion that she presented to others, and that the Act did not prohibit discrimination based solely on the contagious effects of a disease.<sup>177</sup> The Court concluded that it “would be unfair to allow an employer to seize upon the distinction between the effects of a disease on others and the effects of a disease on a patient and use that distinction to justify discriminatory treatment.”<sup>178</sup> Permitting such discrimination would be inconsistent with the purpose of the Act “which is to ensure that handicapped individuals are not denied jobs or other benefits because of the prejudiced attitudes or the ignorance of others.”<sup>179</sup>

In a passage that reveals much about the Court’s sensitivity to the larger social construction of disease and the role of human rights provisions in providing some protection to those victimized by this construction, the Court in *Arline* stated:

[S]ociety’s accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment. Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness ... . The fact that some persons who have contagious diseases may pose a serious health threat to others under certain circumstances does not justify excluding from the coverage of the Act all persons with actual or perceived contagious diseases.<sup>180</sup>

The Court criticized the “complex and often pernicious mythologies about the nature, cause, and transmission of illness”<sup>181</sup> and refused to permit discrimination based solely on these social constructions.

Nonetheless, the Court recognized the legitimate need to prevent exposing others to significant health and safety risks, and acknowledged that a person who poses a significant risk of communicating an infectious disease

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<sup>177</sup>*Supra*, note 155.

<sup>178</sup>*Ibid.* at 1128.

<sup>179</sup>*Ibid.* at 1129.

<sup>180</sup>*Ibid.* at 1129-30.

<sup>181</sup>*Ibid.* at 1129 n.12.

to others in the workplace will not be "otherwise qualified" for their job.<sup>182</sup> Only handicapped individuals who are "otherwise qualified" for their job are entitled to protection under the *Rehabilitation Act*.<sup>183</sup> However, those handicapped with a contagious illness are entitled to "an individualized inquiry" to determine whether their condition presents a significant health and safety risk to others and the courts must base their finding on reasonable medical judgments about the nature, duration, and severity of the risk of contagion.<sup>184</sup> The Court stressed the importance of relying on scientific and medical evidence of the risk of contagion rather than on "prejudice, stereotypes, or unfounded fears."<sup>185</sup>

Although the *Charter* provides no definition of physical disability, the general interpretation of this legal class under Canadian human rights legislation, and the American precedent in *Arline*, together provide a compelling argument that HIV disease, although a contagious illness, constitutes a physical disability under s. 15. It would be unjust to deny constitutional protection to all individuals with contagious diseases, given that the degree of risk of contagion significantly varies among different infectious diseases. It is not unreasonable that measures to control contagious diseases should be subject to constitutional scrutiny, particularly as many of these measures

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<sup>182</sup>*Ibid.* at 1131 n.16.

<sup>183</sup>See *Southeastern Community College v. Davis*, 442 U.S. 397, 60 L.Ed. 2d 980; 99 S. Ct. 2361 (1979): "An otherwise qualified person is one who is able to meet all of a program's requirements in spite of his handicap."

The "otherwise qualified" requirement is similar to the bona fide occupational qualification ("b.f.o.q.") defense which is available in all the Human Rights Codes in Canada. See *Discrimination and the Law*, *supra*, note 152 at 9-22. For a discussion of the content of the b.f.o.q. defense, see *Ontario Human Rights Commission v. Etobicoke (Borough of)* (1981), [1982] 1 S.C.R. 202, 132 D.L.R. (3d) 14.

<sup>184</sup>*Supra*, note 155 at 1131.

<sup>185</sup>*Ibid.* at 1131. The emphasis on scientific evidence is also stressed in *Ontario Human Rights Commission v. Etobicoke (Borough of)*, *supra*, note 183 at 212 [S.C.R.] where the Court stated that mere "impressionistic" evidence that firefighting was "a young man's game" was not sufficient to establish a defense for age discrimination in the employment of firefighters. Statistical and medical evidence on the aging process, a detailed description of the duties performed, and an account of the effect such conditions have on employees are required in order to establish a bona fide occupational qualification. But see *Bhinder and Canadian Human Rights Commission v. C.N.R.* [1985] 2 S.C.R. 561, 23 D.L.R. (4th) 481, where the Court suggested [at 588 S.C.R.] that "a requirement of general application concerning the safety of employees" (in this case, the requirement to wear hard hats) could constitute a b.f.o.q.

Much as the protection for the handicapped under the American and Canadian human rights legislation is subject to reasonable limits, such as the "otherwise qualified" requirement or the "b.f.o.q." defense, protection for the physically disabled under the *Charter* is limited by s.1 which provides that the guarantees of the *Charter* are subject to "reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society." Any constitutional protection available to individuals who are HIV infected is subject to these limits, a question which is considered in the final section of this paper.

involve some of the most extreme deprivations, such as loss of employment, isolation and quarantine, and, in this case, mandatory reporting and contact tracing. Merely because a disease is contagious, individuals and governments should not be free to inflict these deprivations without at least some evidence that the risk of contagion warrants such highly invasive measures.

HIV disease, in particular, is not highly infectious and can only be transmitted through sexual intercourse, blood transfusions, and the shared use of needles.<sup>186</sup> For example, in the case of employment, to permit discrimination on the basis of unfounded and uninformed fears of casual transmission would only increase the stigma of this disease and condone the social rejection of those afflicted. Similarly, with regard to the mandatory reporting of HIV infection, to decline any judicial review merely because HIV disease is infectious would fuel the unfounded fears and anxieties that surround AIDS. Instead of promoting this damaging and inaccurate social construction, it is vital that legal opinion take a lead in protecting those infected with HIV.

Any protection, of course, is subject to limitations, and the safeguarding of the public health is obviously a paramount concern in relation to contagious diseases. Yet these limitations cannot be immune from review merely because they involve a contagious illness, particularly given that our often pervasive but uninformed construction of disease can result in unwarranted discrimination based on unreasonable fears of contagion, or in an ineffective and discriminatory public health policy that does little to contain the spread of infection.

*(b) Asymptomatic HIV Infection as a Physical Disability*

It is somewhat easier to argue that HIV disease that has progressed to AIDS constitutes a physical disability because it is an illness which causes immediate, significant, and life-threatening physical impairment. The same cannot be said of asymptomatic HIV infection.<sup>187</sup> Given that the majority of individuals affected by a mandatory reporting and contact tracing program are individuals with asymptomatic HIV infection, whether this con-

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<sup>186</sup>Of course, contact tracing of HIV infection is precisely designed to address the risk of infection presented by sexual intercourse and IV drug use. Contact tracing is thus much more obviously related to preventing contagion than is employment discrimination based on unfounded fears of casual transmission. The point, however, of this section of the paper is not to examine whether contact tracing is a reasonable response to the risk of contagion; rather, the issue is whether HIV disease constitutes a physical disability and there is no reason, merely because it is contagious, that it should not be considered as such. An appropriate response to the risk of contagion is discussed in the last section of this paper.

<sup>187</sup>See R.A. Kushen, "Asymptomatic Infection with the AIDS Virus as a Handicap under the Rehabilitation Act of 1973" (1988) 88 Col. L. Rev. 563.

dition is considered a physical disability is critical. As noted, although the Court in *Arline* expressly declined to rule on this question, subsequent American judicial decisions and the recently issued United States Department of Justice opinion conclude that asymptomatic HIV infection is a covered handicap under the *Rehabilitation Act*.<sup>188</sup> The British Columbia Human Rights Tribunal in *Biggs* also concluded that asymptomatic HIV infection constitutes a physical disability under the B.C. *Human Rights Act*. There are convincing reasons for so holding.

First, it is not accurate to characterize HIV infection as entirely without physical impairment. Although most individuals who are HIV-infected have not yet developed any severe symptoms of AIDS, HIV infection does have adverse physiological effects on several body systems, such as the hemic, lymphatic and reproductive systems.<sup>189</sup> As a result of HIV infection, an individual can exhibit several abnormal immune functions, such as a decrease in the number of T-helper cells in the blood, which indicate an impaired ability to fight infection.<sup>190</sup> The danger of infection also makes reproduction and sexual intercourse dangerous activities. Because of the high risk of perinatal transmission of the virus, HIV-infected individuals are unable to safely become parents.<sup>191</sup>

Second, as noted above, it is becoming increasingly evident that the clear distinction between asymptomatic HIV infection and AIDS is obsolete.<sup>192</sup> As treatments for HIV infection increasingly become available, the definition of AIDS as a terminal disease is being called into question. Conversely, as evidence mounts that the majority, if not all, HIV-infected individuals will develop some HIV-related illness, the concept of strictly asymptomatic HIV infection is also becoming outmoded. As our understanding of this illness evolves, the artificial dichotomy of asymptomatic HIV infection and AIDS is being replaced by the concept of HIV disease — a chronic infection that produces a continuum of conditions with a great variety of clinical symptomatology in most infected people.

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<sup>188</sup>See *Chalk v. United States District Court*, *supra*, note 160 and *Doe v. Centinela Hospital*, *supra*, note 161. See also *infra*, Part III.

<sup>189</sup>See R.A. Kushen, "Asymptomatic Infection with the AIDS Virus as a Handicap under the Rehabilitation Act of 1973", *supra*, note 187 at 572. As medical diagnostic techniques become more sophisticated, it is becoming possible to detect an increasing number of asymptomatic conditions, such as genetic diseases and cancer, before there are any clinical manifestations. *Ibid.*

<sup>190</sup>T-helper cells are one of the body's primary means to fight infection. *Ibid.* at 580.

<sup>191</sup>See M. Rogers, "Modes, Rate, and Risk Factors for Perinatal Transmission of HIV" (Atlanta, Centers for Disease Control) (abstract) in *AIDS: The Scientific and Social Challenge*, V International Conference on AIDS at 199, where the author notes that "the frequency of transmission from mothers to infants... is around 30%."

<sup>192</sup>See the discussion at *supra*, note 3.

Third, to restrict AIDS discrimination on the basis of physical disability and at the same time permit discrimination on the basis of the underlying condition of AIDS, HIV infection, would entirely defeat the purpose of "protecting handicapped individuals from deprivations based on prejudice, stereotypes, or unfounded fears."<sup>193</sup> HIV-related discrimination is rarely a function of the manifest physical symptoms of the disease, rather this discrimination is almost exclusively informed by fears of contagion. All people with HIV disease, both those asymptotically infected and those with AIDS, are equally subject to these fears which leave them vulnerable to extremely invasive and prejudicial discrimination. Unlike most matters involving the physically disabled, with regard to HIV disease the critical issue for both human rights legislation and the *Charter* is not what discriminatory measures are legitimate given the physical impairment of the disease, but what measures are acceptable given the contagious nature of the illness. Because almost all HIV-related discrimination is rooted in concerns regarding contagion, it is the infectious status of people with HIV disease that must command attention, not the precise nature of their manifest physical impairment. The lack of immediate physical impairment in those asymptotically infected is irrelevant. The central issue must focus on the right of all HIV-infected individuals not to be subject to discriminatory action informed by unfounded fears that are unrelated to any actual risk of contagion. The attitudes of others, rather than any resultant manifest physical disability, may be the primary handicapping effect of the illness, and it is precisely these "accumulated myths and fears about disability and disease" that protection for the handicapped is intended to remedy.<sup>194</sup>

Finally, the recent recognition by the Supreme Court of Canada in *Law Society of British Columbia v. Andrews* that the equality provision in s. 15 extends beyond the enumerated classes, such as physical disability, and can include a "discrete and insular minority", such as non-citizens permanently resident in Canada, is of vital importance to HIV-infected individuals.<sup>195</sup> Wilson J. notes that: "It can be anticipated that the discrete and insular minorities of tomorrow will include groups not recognized as such today"

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<sup>193</sup>*Arline, supra*, note 155 at 1131.

<sup>194</sup>*Ibid.* at 1129.

<sup>195</sup>*The Law Society of British Columbia v. Andrews*, [1989] 1 S.C.R. 143 [hereinafter *Andrews*]. With the exception of LaForest J., the entire Court agreed with the reasons of McIntyre J. and his adoption of the concept of s.15 protection for a "discrete and insular minority" that falls outside of the enumerated classes of interests in s.15. This test was first outlined in the now historic footnote number four in the decision of the U.S. Supreme Court in *United States v. Carolene Products Co.*, 304 U.S. 144 (1938). Wilson J., in concurring reasons, further elaborated on this concept. Although LaForest J. did not expressly refer to the "discrete and insular" category, he agreed that "a group of persons who are relatively powerless politically, and whose interests are likely to be compromised by legislative decisions" are entitled to s.15 review.

and that "the context of the place of the group in the entire social, political and legal fabric of our society" must be considered in determining whether the protection offered by s. 15 is appropriate. In particular, groups "lacking in political power" should be protected from legislative action which "brings about or reinforces the disadvantage" suffered by these groups.

Although this concept is only in its infancy in Canadian constitutional law, and the Court has only provided a very general outline of what might constitute a discrete and insular minority, a compelling argument can be made that HIV-infected individuals do constitute such a group. Although some HIV-infected people may not see themselves as members of a discrete group sharing common characteristics, because HIV infection has affected a broad class of people with little in common (such as gay people, IV drug users, and recipients of blood products), given the minority status of HIV-infected people and the condemning social construction imposed on their status *qua* HIV-infected, it is abundantly clear that society views these individuals as a discrete minority sharing certain characteristics. Social condemnation has unquestionably led to the acutely insular and outcast status of those who are infected. The obvious concerns about being publicly identified as HIV-infected are equally disempowering, limiting the exercise of what political power may be available to this group, and the often inflated concerns and deep-rooted fears about contagion leave them extremely vulnerable to prejudicial discrimination.

More importantly, the extent to which infected people have been able to mobilize themselves and create community-based political and service organizations to meet their needs, indicates that HIV-infected people are not an identifiable group only because they are victimized by social stigma: instead of their group identification being solely a function of their vilified status, many members of this group have successfully defined their shared interests and identity and, much like people with cancer or people in wheelchairs, the twist of fate that has resulted in their illness or disability has not only brought a diverse group of people together, but empowered them. A social group thus emerges.

As the defining characteristic of this group is their status as HIV-infected people, all of whom are presumed to remain continually infectious, the distinction between those who have developed a severe form of HIV infection, AIDS, and those who are asymptomatic, is entirely irrelevant. They are all assumed to be equally contagious and, as this aspect of their condition is the one most likely to attract prejudicial action by others, they all share a common and compelling interest to ensure that measures to contain contagion are reasonable, effective, and as non-intrusive as possible. Whether they are identified as a group of the physically disabled or a discrete and

insular minority, the argument in favour of some form of s. 15 review commands the closest attention.

### C. *Structure of Review under s. 15*

The recent decision of the Supreme Court of Canada in *Andrews* is the first attempt by the Court to test the waters of the equality provisions of the *Charter*. Although *Andrews* may raise more questions than it answers (much to the delight of constitutional scholars), the decision does provide a conceptual framework within which an HIV mandatory reporting and contact tracing program can be examined. Most importantly, the decision resolves first, the critical question regarding who bears the onus of proof to establish whether or not the impugned legislation is reasonable and second, whether different levels of scrutiny will apply to the different classes of interests protected under s. 15.

In *Andrews* the Court held that in order to establish a s. 15 claim, the complainant must first identify a s. 15 interest that has been prejudicially affected by the law in question.<sup>196</sup> It is not sufficient merely to establish, as in the case of HIV disease, that the impugned legislation draws distinctions on the basis of physical disability; it is essential that the complainant also establish that the legislation involves "prejudice or disadvantage".<sup>197</sup> As McIntyre J., speaking for the Court on this point, notes, a "differential impact" is not sufficient to establish a violation of s. 15; the complainant must also consider "the effect of the impugned distinction or classification" and "show that the legislative impact of the law is discriminatory".<sup>198</sup> If this can be established, then under s. 1 the burden of proof shifts to the state where "any justification, any consideration of the reasonableness of the enactment; indeed, any consideration of factors which could justify the discrimination and support the constitutionality of the impugned enactment

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<sup>196</sup>In *Andrews, supra*, note 195 at 164, McIntyre J. raises the possibility that s.15 may only apply to legislation and not other forms of state action such as "governmental or quasi-governmental regulations, rules, or requirements", even though this broader kind of state action is clearly subject to review under other sections of the *Charter* (see *Dolphin Delivery Ltd v. R.W.D.S. Union, Local 580*, [1986] 2 S.C.R. 573). Although in all provinces the inclusion of AIDS as a reportable disease is a regulation, not a legislative act, because the enforcement of a HIV mandatory reporting scheme is intimately rooted in the language of, for example, the *Ontario Health Protection and Promotion Act*, there could be no question that a challenge to this state policy would necessarily impugn a piece of legislation. In any event, it is not the regulation mandating the reporting of AIDS that is the subject of the challenge. Rather it is the legislative provision expressly requiring physicians to report the names all persons who have a reportable disease that is disputed. See the discussion above in Part II.

<sup>197</sup>*Andrews, supra*, note 195 at 180-181 (*per McIntyre J.*). The prejudicial effects of a mandatory reporting scheme were outlined in Part II.

<sup>198</sup>*Ibid.* at 182.

would take place.”<sup>199</sup> McIntyre J. stresses that it is important to keep s. 15 and s. 1 “analytically distinct” because once a violation of s. 15 has been found, under s. 1 the onus rests on the state to establish any justification for this violation.<sup>200</sup> The complainant need only establish that the legislation has a prejudicial and discriminatory impact; the reasonableness of the legislation is a matter to be addressed by the state under s. 1.

In *Andrews*, the Court was also unwilling to adopt the American model where different “standards of scrutiny” are applied to the different classes of interests recognized under equal protection clauses. McIntyre J. considers that this whole issue is subsumed under s. 1 of the *Charter*, under which the reasonableness of the legislation will be examined.<sup>201</sup> This appears to lay to rest any concerns that certain of the enumerated classes of interests in s. 15, such as age discrimination or physical disability, would give rise to a lower level of judicial scrutiny.<sup>202</sup>

#### D. *The Content of s. 1 Analysis*

It has been argued in this paper that HIV infection constitutes a physical disability under s. 15 of the *Charter*. A mandatory reporting and contact tracing program, as mandated by the provincial legislation, prejudicially affects the interests of seropositive individuals by presenting a threat of unwarranted disclosure of their HIV status, thus placing them at a considerable risk of HIV-related discrimination. If the complainant can successfully establish that the impugned legislative scheme has a discriminatory

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<sup>199</sup>*Ibid.*

<sup>200</sup>*Ibid.* at 178.

<sup>201</sup>*Ibid.* at 178-79.

<sup>202</sup>This issue was considered by the Ontario Court of Appeal in *McKinney v. University of Guelph* (1987), 24 O.A.C. 245, a case dealing with the age discrimination under s.15. The Court of Appeal held that unlike American law, different standards of review ought not to be applied to the different classes of interests under s.15 and expressly disapproved of the lower court's finding that age discrimination, because it is not typically based on feelings of “hostility and intolerance” should be viewed “less suspiciously”. Noting that a “particular instance of age or sex discrimination may be massively more hurtful or immeasurably less justifiable than a particular instance of racial inequality”, the Court held that all violations of s.15 should be equally examined under s.1. Rather than ranking the importance of the *class* of interest affected, the Court focussed on the *impact* of the violation on the affected class. If this impact was severe, a closer judicial review was warranted.

This line of reasoning finds no better illustration that in relation to the argument of HIV disease as a physical disability. Although much discrimination on the basis of a physical disability, like age discrimination, may not be based on “feelings of hostility and intolerance”, this cannot be said with regard to a highly feared and stigmatized contagious illness. Further, given that these fears could result in the most severe kinds of prejudicial action, such as quarantine, if these measures were unwarranted, this would constitute a “massively hurtful” violation of the *Charter*. It is the drastic nature of the legislative action that should command judicial attention, not any a priori classification of the nature of the interest affected.

and prejudicial impact, the burden then shifts to the state under s. 1 to establish that its mandatory reporting and contact tracing program is a "reasonable limit ... demonstrably justified in a free and democratic society."<sup>203</sup>

In *Andrews*, the s. 1 review procedure adopted by the Court is a modified version of the analytical structure of s.1 earlier outlined by the Chief Justice in *R. v. Oakes*<sup>204</sup> and *R. v. Edwards Books and Art Ltd.*<sup>205</sup> In *Andrews*, the Court essentially adopted a two-part s. 1 analysis. First, the Court examines the nature and purpose of the enactment, with a view to deciding whether the government interest or policy objective is of sufficient importance to warrant overriding a provision of the *Charter*. Wilson J., supported by two of the five other justices who participated in the decision,<sup>206</sup> argued that the government objective must be "pressing and substantial" in order to override the *Charter*, thus adopting the more "onerous" standard earlier outlined in *R. v. Oakes*.<sup>207</sup>

The remaining three justices disagreed with Wilson J.'s position. McIntyre J., joined by Lamer J., argued that this standard "may be too stringent for application in all cases" and proposed a somewhat lower test: the Court should examine the nature and purpose of the enactment "with a view to deciding whether the limitation represents a legitimate exercise of the legislative power for the attainment of a desirable social objective which would warrant overriding constitutionally protected rights."<sup>208</sup> It appears that the government objective need only be "legitimate" under this test, rather than "pressing and substantial".<sup>209</sup>

<sup>203</sup>On s.1 analysis, see generally R.M. Elliot, "The Supreme Court of Canada and Section 1 — The Erosion of the Common Front" (1987) 12 Queen's Law J. 277; and J. Cameron, "The Forgotten Half of *Dolphin Delivery*: A Comment on the Relationship Between the Substantive Guarantees and Section 1 of the Charter" (1988) 22 U.B.C. L. Rev. 147.

<sup>204</sup>[1986] 1 S.C.R. 103, 26 D.L.R. (4th) 200 [hereinafter *Oakes* cited to S.C.R.] (s.1 analysis of the reverse onus provision of the *Narcotic Control Act* which violated s.11(d) ("innocent until proven guilty") and s.7 ("right to life, liberty, and security of the person") of the *Charter*).

<sup>205</sup>[1986] 2 S.C.R. 713 [hereinafter *Edwards*] (s.1 analysis of Sunday closing legislation which violated s.2(a) "freedom of conscience and religion" of the *Charter*).

<sup>206</sup>Dickson C.J., and L'Heureux-Dubé J..

<sup>207</sup>*Andrews, supra*, note 195 at 153-54 per Wilson J., citing *Oakes, supra*, note 204 at 138-39 per Dickson C.J.C..

<sup>208</sup>*Andrews, ibid.* at 184 per McIntyre J..

<sup>209</sup>LaForest J.'s position was less structured. He stressed that the s.1 "analysis should be functional, focussing on the character of the classification in question, the constitutional and societal importance of the interests adversely affected, the relative importance to the individuals affected of the benefit of which they are deprived, and the importance of the state interest." [*Ibid.* at 198]. Although in "general agreement" with McIntyre J., LaForest J. adds one qualification: he would prefer "to think in terms of a single test for s.1, but one that is to be applied to vastly differing situations with the flexibility and realism inherent in the work 'reasonable' mandated by the Constitution." [*Ibid.*] The evaluation of the state objective would be only

The second step of the two-part s. 1 analysis focusses on what the Court refers to as the "proportionality test". Wilson J. describes this test as an examination of "the nature of the right, the extent of its infringement and the degree to which the limitation furthers the attainment of the legitimate goal reflected in the legislation."<sup>210</sup> McIntyre J. largely agreed with this description, but to it he would have added that the inquiry also involves an examination of "the importance of the right to the individuals or group concerned, and the broader social impact of both the impugned law and its alternatives."<sup>211</sup> This formulation of the proportionality test thus enjoys the support of at least five of the six judges on the panel, and it can be confidently relied upon as the best indicator of where the Court will be heading in future equality cases.

Given the new complexities of s. 15 analysis, it comes as no surprise that the Court in *Andrews* seems to make a strategic retreat from the broad language that the Chief Justice previously employed in *Edwards* to describe the proportionality test under s. 1, where it was held that measures violating the guarantees of the *Charter* had to be "rationally connected" to the state objective, to "impair as little as possible" the right in question, and to "not so severely trench on individual or group rights that the legislative objective, albeit important, is nevertheless outweighed by the abridgment of rights."<sup>212</sup>

Although Wilson J. cites *Edwards* as supporting her formulation of the proportionality test, McIntyre J. pointedly avoids citing this language from *Edwards*, and the test that both Wilson J. and McIntyre J. articulate expressly avoids the more sweeping implications of the *Edwards* test. Although under their test the impugned legislation must "further the attainment" of the legislative objective, it does not appear to have to meet the stricter standard of being "rationally connected" to this objective as outlined in *Edwards*. Although McIntyre J. will consider "the broader social impact of the law and its alternatives", this is an important retreat from the language in *Edwards* which held that the legislation must impair "as little as possible" the right in question. McIntyre J., while willing to consider alternative legislative schemes, is conscious that the legislature must be given "reasonable room to manoeuvre" and is obviously very anxious to avoid involving the courts in closely weighing the merits of various legislative options to determine which one impairs "as little as possible" the right in question.

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one consideration of many under LaForest J.'s proposal; it would not form the first of a two part s.1 analysis. Although he does not expressly state his position, he would appear to largely concur with McIntyre J.'s argument that the state interest does not need to be "pressing and substantial".

<sup>210</sup>*Ibid.* at 154 per Wilson J.

<sup>211</sup>*Ibid.* at 184 per McIntyre J.

<sup>212</sup>*Edwards, supra*, note 205 at 768.

Finally, the formulation of the proportionality test in *Andrews* has been uniquely tailored for the new demands of s. 15 analysis: the Court recognized the importance of examining both the nature of the s. 15 right being violated and the extent of the violation. Implicit in the Court's formulation of the proportionality test is the recognition that discrimination on the basis of, for example, race or religion would rarely be tolerated, and the Court thus acknowledged that the nature of the right affected may be a critical factor. Other enumerated grounds in s. 15, such as age or physical disability, which can frequently give rise to legitimate differential treatment, may not create a similar presumption. Unlike American equality jurisprudence, however, the classification of the right is not conclusive. Rather, the Court will also examine the extent to which the right is violated. The Court thus appears to have recognized that a highly prejudicial instance of discrimination on the basis of physical disability, because of the severe extent of the violation, may command closer review than a relatively minor instance of discrimination on the basis of religion, for example, that has only a minimal impact.

Although much remains unclear about the s. 1 analysis of violations of s. 15, *Andrews* does provide some critical direction. First, the objective of the legislation must be considered, and second, a somewhat revised proportionality test is applied to determine whether the violation is "demonstrably justified". With these directives in mind, what follows is a s. 1 analysis of an HIV mandatory reporting and contact tracing program.

#### 1. Does HIV Mandatory Reporting Protect Public Health?

A s. 1 review of an HIV mandatory reporting program is not unlike the criteria that have been described by Professor Grad in his *Public Health Law Manual* where he formulates a general standard for the evaluation of public health legislation:

Does this law or regulation have a valid and demonstrable public health purpose? And if so, are the requirements of this law or regulation ... reasonably designed to accomplish that purpose under the existing circumstances, without causing hardships or dislocations unrelated or unnecessary to that purpose? If these questions cannot be answered in the affirmative, then the proposed law or regulation will ... fail ... to meet the requirements of public health.<sup>213</sup>

In the language of *Andrews* and in the context of *Charter* review, this public health inquiry could be presented as follows: first, it must be established that mandatory reporting has a demonstrable public health purpose; and second, mandatory reporting must further the attainment of this public

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<sup>213</sup>F.P. Grad, *Public health law manual; a handbook on the legal aspects of public health administration and enforcement*, 3d ed. (New York: Am. Pub. Health Ass'n, 1973) at 40.

health objective without unacceptably trenching on the equality rights of those affected.

Even under the more onerous duty outlined by Wilson J. in *Andrews*, whereby the government must establish that its legislative objective is "pressing and substantial", there can be no question that the public health objective behind mandatory reporting, that of protecting public health and preventing the spread of HIV infection, is of critical importance and would undoubtedly justify some interference with equality rights.<sup>214</sup>

The much more difficult question is whether the means chosen to pursue this government objective are reasonable and demonstrably justified, that is, whether they meet the proportionality test under s.1. Both the nature of the right affected by mandatory reporting and the highly prejudicial impact of an HIV mandatory reporting scheme have been described in detail above. As is made clear in *Andrews*, an evaluation of the relative importance of providing protection to this class of interests, and a consideration of the extent to which the interests of this class are violated, are both critical elements of the proportionality test. However, the test upon which a mandatory reporting scheme will either rise or fall, be it under the proportionality test or Professor Grad's public health criteria outlined above, is whether mandatory reporting in fact furthers the attainment of the government objective of protecting public health and preventing the spread of HIV, or whether alternative measures are available which are both more effective and significantly less invasive.

Numerous reasons have been advanced to defend the public health objective of mandatory reporting. Most obviously, mandatory reporting of HIV infection with identifiers is required if the province is to conduct a state-supervised contact tracing program, and the public health objective of contact tracing is discussed in detail below. Although additional reasons for mandating the reporting of HIV infection have been proposed, they are not reasonably related to any public health objective.

First, it has been argued that the reporting of HIV infection serves a valuable epidemiological function by providing information about the extent and spread of HIV infection. In fact, the reporting of all findings of HIV seropositivity and all cases of full-blown AIDS are statistically distinct; only the second provides significant epidemiological information.<sup>215</sup> Surveillance of the incidence of full-blown AIDS is essential in order to better

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<sup>214</sup>Section 2 of the Ontario *Health Promotion and Protection Act*, *supra*, note 10 states that "The purpose of this Act is to provide for . . . the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario."

<sup>215</sup>"AIDS: Legal and Policy Implications", *supra*, note 141 at 29-30; and *Confronting AIDS*, *supra*, note 1 at 118-9.

understand and curb the spread of the disease.<sup>216</sup> The mandatory reporting of all cases of AIDS to both the provincial Medical Officer of Health and the Federal Centre for AIDS provides this vital epidemiological information.<sup>217</sup> The reporting of all seropositive individuals, on the other hand, serves only a very limited epidemiological function. Individuals seeking HIV testing are self-selected: they are likely to be members of one of the recognized groups at a greater risk for HIV infection and the data collected from these tests would not provide a reliable gauge of the extent of exposure beyond these groups.<sup>218</sup>

Whatever limited epidemiological information reporting of HIV infection may provide, it does not in any event require that infected individuals be identified by name; initials and date of birth, for example, are sufficient to prevent any duplication of records.<sup>219</sup> There is no rational connection between the reporting of the names of seropositive individuals and the public health objective of securing epidemiological information useful in curbing the spread of AIDS.

In defense of the reporting of HIV-infected individuals by name, it is also argued that if the public health authorities have the names of infected individuals, the government can ensure that they receive adequate post-test counselling about how to prevent placing others at risk of infection. When

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<sup>216</sup>Surveillance provides "data on the prevalence, incidence, and distribution of disease or infection in the population. Such data can be used to monitor the spread of a disease, to shed light on the mechanisms of transmission, to help in designing public health measures to prevent the spread of a disease, to evaluate the effectiveness of interventions, and to guide planning for the provision of facilities. Data on HIV infection and related diseases are critical to all aspects of coping with the epidemic." *Confronting AIDS, supra*, note 1 at 117.

<sup>217</sup>The reporting of AIDS for epidemiological purposes does not require that patients be identified by name. Neither the Federal Centre for AIDS nor the Atlanta Centers for Disease Control identify AIDS cases by name. See the discussion above in Part II.

<sup>218</sup>The most accurate method to obtain epidemiological information about the extent of HIV infection in the entire population is to conduct anonymous tests of representative groups such as in New York State where all babies born in the state for a period of six months were given anonymous HIV tests. See "AIDS Survey Shows Course of Infection" *The New York Times* (15 July 1988) B1. In the United States, seroprevalence studies are also conducted in prisons and drug treatment centers. See *AIDS: A Public Health Challenge, supra*, note 66 3-14 to 3-15.

<sup>219</sup>For example, the State of Oregon requires the reporting of HIV antibody test results without personal identifiers. Oregon's Task Force on AIDS, noting the stigma associated with AIDS, stated that "mandatory reporting, by name, of positive HIV antibody tests. . . will discourage many from seeking the test and thus lead to a serious under-estimate of the number actually infected." The form includes demographic information including the patient's age, sex, and county of residence, thus permitting more accurate data for epidemiologic studies. See *AIDS: A Public Health Challenge, ibid.* at 3-37.

effective AIDS treatments become available, the authorities will also be able to contact persons who are at risk of developing AIDS.<sup>220</sup>

The State of Oregon, where the reporting of HIV infection without identifiers is required, is able to accomplish both these objectives without requiring that the names of those testing positive be reported.<sup>221</sup> In Oregon, all health care providers who request an HIV antibody test are at the same time required to fill out a form verifying that the patient has been given state-approved educational materials about AIDS and measures to prevent the transmission of HIV. The State also maintains lists of physicians requesting the test so that if anti-viral HIV therapies become available, the public health department will be able to notify the physicians. The Oregon program successfully illustrates that the reporting of HIV infection with identifiers is not required in order to ensure proper counselling and the availability of information about current HIV treatments.<sup>222</sup>

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<sup>220</sup>See *AIDS: A Public Health Challenge*, *ibid.* at 3-9 to 3-13. At least seven states in the United States currently require the reporting of HIV infection with identifiers (Arizona, Colorado, Idaho, South Carolina, Minnesota, Missouri, and Wyoming) [*ibid.* at 3-12]. Nonetheless, anonymous testing is also available in these states, as is the case in all states, at Alternate Test Sites. A more recent study presented at the Fifth International Conference on AIDS (June 1989) found that as of October 1988, sixteen states required the reporting of HIV infection with names. See J. Stehr-Green, "HIV Infection Reporting in the United States" (Atlanta: Centers for Disease Control) (abstract) in *AIDS: The Scientific and Social Challenge*, V International Conference on AIDS at 59.

Of the states with reporting requirements, Colorado has most aggressively pursued the reporting of the names of seropositive individuals. The stated purpose of the Colorado regulation is to: (a) alert authorities of the presence of HIV infected individuals, (b) ensure proper counselling, (c) monitor the incidence of infection, and (d) contact tracing. See *Confronting AIDS*, *supra*, note 1 at 118.

<sup>221</sup>See *AIDS: A Public Health Challenge*, *supra*, note 66 at 3-37.

<sup>222</sup>This may not be the case where the majority of instances of HIV infection is found in the IV drug use population. At the recent Fifth International Conference on AIDS, Molly Coye of the New Jersey State Department of Health presented a cogent argument in favour of mandatory reporting in such circumstances (60 per cent of AIDS cases in New Jersey are IV drug users). Although noting that the quality of epidemiological information derived from HIV reporting is low, and the costs of contact tracing are extremely high, she nonetheless argued for some kind of reporting enabling the Department of Health to ensure that HIV-infected IV drug users could benefit from new HIV treatments as they become available (for example, the use of prophylaxis can now prevent the onset of PCP pneumonia—a leading cause of death in AIDS patients). Unlike other individuals at risk for HIV disease, IV drug users may not have access to appropriate medical facilities and will not be able to benefit from new treatments unless they can be located by health officials.

Although the argument is compelling in New Jersey where the majority of AIDS patients are IV drug users who probably have no health insurance, the situation is very different in Ontario where all citizens have free access to health care and only a minority of AIDS cases to date are found in the IV drug use population. In any event, Coye agreed that any reporting scheme can only operate effectively if anonymous HIV tests are also freely available, in case the patient does not want test results reported to the Department of Health. See M. Coye, "The Role of HIV Infection Reporting in Public Health" (abstract) in *AIDS: The Scientific and Social Challenge*, V International Conference on AIDS at 59.

In fact, the only reason for which the reporting of HIV-infected individuals by name is necessary is in order to facilitate state-supervised contact tracing. It serves no other legitimate public health purpose. Mandatory reporting of names is not necessary for epidemiological requirements, and proper counselling about AIDS can effectively be addressed by far less invasive means.

## 2. Does Contact Tracing Protect Public Health?

The primary objective behind contact tracing is to interrupt the cycle of infectious disease.<sup>223</sup> Contact tracing was first devised in the 1930s as part of the effort to treat venereal disease; officials identified the sexual contacts of a venereal disease patient, informed them of the possibility of infection, and, if necessary, treated them.<sup>224</sup> Unlike venereal disease, there is as yet no effective treatment for HIV infection, although anti-virals such as azidothymidine ("AZT") and certain treatments for opportunistic infections have proven effective in slowing the progression of the disease. Although the treatment of HIV infection is becoming an increasingly important objective, the primary purpose of HIV contact tracing remains the need to inform individuals who have no idea that they are at risk of HIV infection from unknowingly acquiring or transmitting infection.<sup>225</sup> It can also be argued that individuals have the right to know that they may have been exposed to HIV, separate from any risk they may present to others, even though this involves burdening the contact with the knowledge that he or she may in the future develop a fatal disease.<sup>226</sup>

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<sup>223</sup>"AIDS: Legal and Policy Implications", *supra*, note 141 at 30.

<sup>224</sup>A.M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States Since 1880*, *supra*, note 26 at 150-51.

<sup>225</sup>*AIDS: A Public Health Challenge*, *supra*, note 66 at 3-16. As treatments are developed, it will become more and more critical that all HIV-infected persons be aware of their HIV status so that they can consider options for early treatment. However, to date only a fraction of those infected with HIV know their HIV status (for example, 88 to 94 per cent of people infected with HIV in New York City have never been tested for the virus: see "With Few Tested, AIDS Debate Erupts" *The New York Times* (23 July 1989)). As a result, there are increasing calls for some form of contact tracing which might ensure that more people infected with HIV would be informed of their status and seek treatment. Nevertheless, even those in favour of contact tracing for these purposes, such as Dr Stephen C. Joseph, New York City Health Commissioner, at the same time recognize that it is also essential that anonymous testing be available in order to protect confidentiality. [*Ibid.*] There is little doubt that the provision of anonymous HIV tests will remain the most important means by which to encourage people to determine their HIV status.

<sup>226</sup>"[I]ndividuals who may have no reason to suspect that they may have been exposed to HIV should have the opportunity to know that they may have been so exposed.", National Advisory Committee on AIDS, "HIV Infection Contact Tracing Recommendations" (1987) 13:4 *Canada Diseases Weekly Report*.

Because health education designed to modify high-risk sexual behavior and IV drug use is the only means currently available to prevent the spread of HIV, education is a critical aspect of containing this epidemic. As part of a general HIV education program, contact tracing can be useful because it permits health-care professionals to target individuals unknowingly at risk of HIV infection who, notwithstanding the general attempts to educate the public about HIV transmission, may not have altered their high-risk activity and continue to present a risk of infection to others. Individual counselling of these individuals has been shown to be effective in encouraging behaviour changes and reducing the transmission of HIV in some groups.<sup>227</sup>

For example, women of child-bearing age are usually the highest priority of any HIV contact tracing program.<sup>228</sup> These women, possibly the sexual partners of closeted bisexual males or IV drug users who are HIV-infected, may have no knowledge of the risk of exposure, and should they choose to have children there is a significant risk that the child will be infected if the mother is already infected. Contact tracing enables these women to delay pregnancy or consider an abortion.

Contact tracing has also proven useful in encouraging a reduction of high-risk activity in rural areas where there may be a significant number of people who remain unaware of the risk of HIV transmission and the need to alter high-risk behaviour.<sup>229</sup> Because there may be a perception in rural areas that there is a lower risk of HIV transmission than in urban areas, and because general attempts to educate the public about these risks may be largely confined to urban centres with higher seroprevalence rates, contact tracing in this setting could be useful. In particular, because the gay community is likely undeveloped in rural areas, unlike in most urban areas, there may have been little attempt by this community to educate itself about the risk of HIV infection. Men who are having sex with men in these settings may not even primarily regard themselves as gay and thus assume that they are not at risk even though they continue to practice high risk behavior. Contact tracing in this particular setting can be effective in reducing the transmission of HIV.

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<sup>227</sup>See M. Becker & J. Joseph, "AIDS and Behavioral Change to Reduce Risk: A Review" (1988) 78 *Amer. J. Pub. Health* 394.

<sup>228</sup>Perinatal transmission of HIV presents a significant danger that a child will be born HIV infected. "HIV Infection Contact Tracing Recommendations", *supra*, note 224 at 13. See also "Partner Notification for Preventing Human Immunodeficiency Virus (HIV) Infection- Colorado, Idaho, South Carolina, Virginia" (1988) 260 *J. Amer. Med. Assoc.* 613 at 615 (where the Center for Disease Control in Atlanta considers the contact tracing programs in effect in these states and concludes that "the partner-notification process can target risk-reduction messages to those at greatest risk of acquiring or transmitting infection").

<sup>229</sup>R.F. Wykoff *et al.*, "Contact Tracing to Identify HIV Infection in a Rural Community" (1988) 259 *J. Amer. Med. Assoc.* 3563.

Outside of these limited examples, however, contact tracing is at best only marginally effective in reducing the spread of HIV.<sup>230</sup> First, HIV infection, especially in its asymptomatic stage, is currently an underdiagnosed disease. Until an effective antiviral therapy becomes available, it is likely that only a small minority of HIV-infected individuals will be diagnosed,<sup>231</sup> and contact tracing is unlikely to identify a significant number of the over 30,000 Canadians infected with HIV. Second, a large number of exposed sexual partners may not be locatable, given that a seropositive individual could have presented a risk of infection to all of his or her sexual partners over the last five to ten years. Third, contact tracing is labour-intensive and potentially very expensive.<sup>232</sup> Particularly in urban areas with high seroprevalence rates and multiple sexual partners, contact tracing could prove prohibitively expensive and public funds might be much more effectively spent on general education programs, especially those designed to reach groups of individuals practising high-risk behaviour.

Contact tracing is useful only as an adjunct to current HIV risk-reduction programs; it must be "tailored to complement, rather than compete with, the primary tool for HIV prevention, education."<sup>233</sup> Its usefulness is essentially restricted to reaching women of child-bearing age, and homosexual and bisexual men in low-prevalence or rural areas. In these circumstances, however, it is evident that contact tracing fulfills an important public health function related to the prevention of the spread of HIV. What is not clear, however, is whether the mandatory reporting of the *names* of all seropositive individuals must be systematically reported to the state in order to ensure that contact tracing, where appropriate, will be performed.

Although most public health studies favour some limited form of HIV contact tracing, they unanimously stress the critical importance of anonymous HIV testing in preventing the spread of HIV infection.<sup>234</sup> These studies

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<sup>230</sup>See G.W. Rutherford & J.M. Woo, "Contact Tracing and the Control of the Human Immunodeficiency Virus Infection" (1988) 259 J. Amer. Med. Assoc. 3609.

<sup>231</sup>If the names of seropositive individuals are reported to the state, it is likely that an even smaller fraction of HIV infection is being identified, because fewer people would be willing to request an HIV antibody test under these circumstances.

<sup>232</sup>See *AIDS: A Public Health Challenge*, *supra*, note 66 at 3-29, 3-30. In Oregon, for example, it is estimated that its costs \$95 for each person counselled, tested, or notified under its contact tracing program.

<sup>233</sup>G.W. Rutherford & J.M. Woo, "Contract Tracing and the Control of the Human Immunodeficiency Virus", *supra*, note 230 at 3610.

<sup>234</sup>See "AIDS: Legal and Policy Implications", *supra*, note 141 at 29-31 (1987); and L. Gostin, M. Clark, and W. Curran, *Acquired Immunodeficiency Syndrome: Legal and Regulatory Policy*, *supra*, note 116 at 329-35. See also *Confronting AIDS: Update 1988*, *supra*, note 3 at 80-82 (where the Institute of Medicine of the National Academy of Science recommends that "mandatory reporting of seropositive test results with identifiers should not be required at this time" [at 82] because even though the reporting of HIV infection "is consistent with the view that

typically recommend that physicians be primarily responsible for initiating contact tracing where appropriate. The state generally only participates in the contact tracing upon the request of the physician, and the results of all HIV tests with identifiers are not systematically reported to the state.

A contact tracing program based on mandatory reporting is simply not effective in reducing the spread of HIV. Numerous public health studies conclude, on the basis of overwhelming evidence, that unless confidentiality can be assured by anonymous testing, individuals will be discouraged from seeking voluntary HIV tests, thereby effectively preventing the early detection of HIV exposure and depriving individuals of the opportunity to receive counselling and information about behaviour changes that could decrease the risk of transmitting the HIV infection.<sup>235</sup> Mandatory reporting, rather

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the disease is really a continuum from HIV infection to AIDS", this argument "is not sufficiently compelling to risk deterring individuals from being tested" [at 82]. The Institute instead recommends a voluntary, limited contact notification program that does not involve mandatory reporting [at 81-2]. For a discussion of the evolution of American public health policy on this question, see, R. Bayer, *Private Acts, Social Consequences: AIDS and the Politics of Public Health* (New York: Free Press, 1989) at 101-36. For public health studies in Canada see *AIDS: A Perspective for Canadians, supra*, note 2 at 10-11 (which recommended the provision of anonymous HIV testing and a limited form of contact tracing: disclosure of HIV status without the patient's consent only if the health care provider has reasonable cause to believe that the HIV infected person may present a threat to others); M. Somerville & N. Gilmore, "Human Immunodeficiency Virus Antibody Testing in Canada" (Montreal: McGill Centre for Medicine, 1987) (a study undertaken for consideration by the National Advisory Committee on AIDS of Health and Welfare Canada which also recommended the provision of anonymous HIV tests and limited contact tracing by the health care provider); and the *CBA Report, supra*, note 4 at 44-56 (which recommended that personal identifiers "should be omitted from the reporting procedures" [at 49] because reporting requirements may "inhibit certain members of high-risk groups from coming forward for voluntary testing" [at 48]. The report recommended a limited contact tracing program where the "initial obligation for contact tracing should be placed on the patient's physician" [at 52]. Only physicians unwilling to perform contact tracing would be required to report the identity of the patient to enable the Medical Officer of Health to proceed with contact tracing [at 52].]

<sup>235</sup>A study done in Oregon in 1986 found that the provision of anonymous (clients identified only by number) versus confidential (clients required to give name, birthdate, address and telephone number) HIV antibody testing increased the number of clients at Oregon test sites by 50 per cent, ranging from 17 per cent for IV drug users to 125 per cent for gay men. The study showed that anonymous testing preferentially drew gay men, currently the group in Oregon with the highest risk of HIV infection. See *Public HIV Testing: Anonymous or Confidential?* [March 1987] also reported in AIDS Health Project University of California San Francisco, *Focus: A Guide to AIDS Research*, vol. 3, No. 12 and *The Lancet* (13 August 1988). Oregon's task force on AIDS thus recommended that positive HIV antibody tests be reported anonymously to the public health officials. See *AIDS: A Public Health Challenge, supra*, note 66 at 3-37.

A more recent study presented at the Fourth International Conference on AIDS in Stockholm, Sweden (Johnson, Ky, Jackson, "The Impact of Mandatory Reporting of HIV Seropositive Persons in South Carolina" (Univ. of South Carolina School of Public Health, 1988) (Abstract No. 6020), reported in Lambda Legal Defense and Education Fund, *AIDS Update*, vol.2, No.11

than increasing the number of people who will be encouraged to seek out HIV testing and counselling, may actually have the opposite effect. Alternative contact tracing programs that do not involve mandatory reporting are simply a much more effective way to prevent the spread of HIV.

### 3. Alternative Contact Tracing Programs

Although the courts will consider less invasive alternatives to legislation that violates equality rights, there is no question that the courts will refuse to be enticed into detailed fine-tuning of legislative decisions. McIntyre J. in *Andrews* emphasized that legislatures continually make "distinctions and categorizations in the pursuit of the role of government", many of which could give rise to some s. 15 challenge.<sup>236</sup> Citing the Chief Justice in *Edwards*, McIntyre J. notes that the courts "are not called upon to substitute judicial opinions for legislative ones as to the place at which to draw a precise line."<sup>237</sup>

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(August 1988) at 5-6) found that the rate of monthly attendance by men reporting homosexual activity decreased by 51 per cent after implementation of a mandatory reporting policy. Attendance by seropositive persons decreased by 43 per cent. The researchers concluded that mandatory reporting is associated with a decrease in attendance for testing and counselling by individuals most at risk for exposure to HIV. On the other hand, in Colorado, the first state to require the mandatory reporting of the names of seropositive individuals, state officials believe that there has been no noticeable decrease in the number of individuals who volunteer to be tested since the reporting began. See *ibid.* at 3-38, and F. Judson & T. Veron, Jr., "The Impact of AIDS on State and Local Health Departments: Issues and a Few Answers" (1988) 78 *Amer. J. Pub. Health* 387 at 390. Officials believe that the greatest impediment to expanded voluntary testing is the fear of facing a positive result, not any fear of names being reported. It should be noted, however, that Colorado public health officials have expressly announced their willingness to use pseudonyms in their testing program in order to alleviate any concerns about confidentiality, which obviously defeats the purpose of obtaining identifying information. It would also explain why they have not experienced a large reduction in voluntary testing. See also R. Bayer, *Private Acts, Social Consequences: AIDS and the Politics of Public Health*, *supra*, note 234 at 119-21.

A pamphlet widely distributed by the AIDS Committee of Toronto *This is a Test—This is Only a Test* (November 1987) stresses that the results of HIV tests are reported to provincial health officials which could result in contact tracing and AIDS-related discrimination. The pamphlet points out that the "only effective way to protect confidentiality is to have the test done anonymously," and provides information on how to obtain an anonymous test. The pamphlet provides some indication that the groups at a greater risk of HIV infection are well informed of the mandatory reporting requirements in Ontario and of the critical need to secure anonymous testing. It is reasonable to conclude that if this anonymous testing were not freely (although illegally) available at the Hassle Free Clinic in Toronto, the number of voluntary HIV testing performed in the city would dramatically drop, as was the case in Oregon and South Carolina.

<sup>236</sup>*Andrews*, *supra*, note 195 at 190-91 *per* McIntyre J..

<sup>237</sup>*Ibid.* citing *Edwards*, *supra*, note 205 at 781-82 *per* Dickson C.J.C.

In *McKinney v. University of Guelph*, a case dealing with age discrimination under s. 15, the Ontario Court of Appeal equally emphasized the limited role for the courts in examining alternative legislative schemes. In *McKinney*, the Court examined legislative provisions permitting mandatory retirement and concluded that mandatory retirement at age sixty-five was a reasonable impairment of the right to freedom from age discrimination, noting that "legislation does not have to be tuned with great precision to withstand judicial scrutiny, and it is not our role to consider how the legislation might have been made more precise."<sup>238</sup> As in *Edwards*, where the Court declined to consider whether employers with more than seven employees and who observed the Saturday Sabbath were constitutionally entitled to be exempt from Sunday closing laws, the courts will refuse to be drawn into detailed balancing of interests. Provided the legislature draws a reasonable line, to be determined rather broadly within its discretion, the courts will likely decline to interfere.

Notwithstanding this judicial caution, the impugned legislation in *Andrews*, which restricted entry to the bar to Canadian citizens only, was struck down by the Court. Wilson J., joined by Dickson C.J.C. and L'Heureux-Dubé J., held that the citizenship requirement was not "carefully tailored to achieve" the legislative objective of ensuring that Canadian lawyers were familiar with Canadian institutions and customs.<sup>239</sup> LaForest J. agreed and noted that "less drastic means for achieving these objectives are available", such as a declaration of an intention to become a citizen.<sup>240</sup>

Although it is recognized that contact tracing is rationally connected to a public health objective which justifies some impairment of a s. 15 guarantee, the various contact tracing programs that can be employed dramatically differ from one another, unlike the legislative options considered in *McKinney* and *Edwards*. Simply put, one involves mandatory reporting and the other does not. The examination of these alternatives is not a question of detailed fine-tuning of legislation. Like the legislative option available in *Andrews* which led LaForest J. to comment that a "less drastic means" was available to pursue the government objective, there are alternative contact tracing programs which much less seriously impair the interests of HIV-infected people and more successfully promote the objective of the protection of public health.

There are essentially two options available to the legislature. As in Ontario, the first involves the mandatory reporting of HIV infection with

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<sup>238</sup>*McKinney, supra*, note 204 at 288. At the same time, however, the Court noted that this level of scrutiny was greater than the rational basis test in American constitutional law [at 286].

<sup>239</sup>*Andrews, supra*, note 195 at 156 per Wilson J..

<sup>240</sup>*Andrews, ibid.* at 201 per Laforest J..

identifiers and a state-supervised active contact tracing program where the state assumes the obligation to identify all HIV-infected individuals and conduct the contact tracing. Under the Ontario scheme, if patients refuse to perform their own contact tracing, the Medical Officer of Health will intervene. Apart from the reporting requirements governing HIV infection, a physician may not reveal HIV-related information to anyone and doing so would likely constitute professional misconduct.<sup>241</sup>

In the second alternative, the results of HIV tests with identifiers are not systematically reported to the government and the public health officer does not assume the primary responsibility to identify seropositive individuals and perform contact tracing. Rather, the primary obligation to perform contact tracing is left with the physician, who is entitled to proceed with contact tracing even without the patient's consent if this patient represents a genuine risk to others.<sup>242</sup> This second alternative addresses the legitimate concerns about confidentiality by ensuring that the results of HIV tests with identifiers are not systematically reported to the government, yet at the same time third parties who are unknowingly at risk for HIV infection will be informed. Given that this second option much less seriously trenches on a s. 15 interest by more carefully ensuring the confidentiality of HIV-related information, which in turn more effectively promotes the public health objective of encouraging individuals to determine their HIV antibody status, it merits the close attention of both the courts and the public health officials who must balance the vital interests at stake.

This second option has been adopted by the New York State Legislature which has recently enacted legislation that provides an important compre-

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<sup>241</sup>See the discussion above in Part II.

<sup>242</sup>The second alternative outlined in this paper significantly differs from the private member's bill introduced last year by Dr Jim Henderson, Liberal M.P.P. for Humber. See *supra*, note 115 and accompanying text. Dr Henderson's bill would amend the Ontario *Health Promotion and Protection Act* and provide individuals with the option to request an anonymous HIV test. His bill would also amend the *Health Insurance Act*, R.S.O. 1980, c. 197 and provide that anonymous HIV tests would be an uninsured service under the Ontario Health Insurance Plan, so that patients could not be traced through their OHIP billing records. His bill does not, however, make any provision for physician-performed contact tracing, arguing that this would constitute "an unconscionable violation of human rights to privacy, and a major departure from the traditional confidentiality of the doctor-patient relationship. All those who argue that this blatant breach of confidentiality is a necessary step to protect the public interest is (*sic*) simply wrong." (See Dr Henderson, Press Release, *supra*, note 115).

As discussed above in Part III, in some circumstances, contact tracing does serve a legitimate public health objective. Dr Henderson's argument in favour of anonymous testing is not strengthened by his absolute opposition to contract tracing in all cases. Rather, as in the second alternative outlined above, it is possible to secure access to anonymous testing where the results are not reported to the government and at the same time permit disclosure of this information in the exceptional circumstance of risk to a third party.

hensive public health model for the reduction of the spread of HIV infection.<sup>243</sup> The legislation has two primary objectives: first, to protect public health by encouraging the expansion of confidential testing and second, to limit the risk of discrimination against persons with AIDS and HIV infection by restricting the disclosure of HIV-related information.<sup>244</sup> Under the legislation, HIV related tests may only be performed with the patient's written, informed consent, including a statement which explains the purpose and meaning of the test, informs the patient that the test is voluntary and may be done on an anonymous basis at the option of the patient, and explains to the patient the circumstances under which disclosure of this information may be required or permitted under the Act.<sup>245</sup>

Disclosure of HIV-related information is closely governed by the New York legislation.<sup>246</sup> Disclosure is generally permitted to health facilities where it is necessary to provide appropriate care, where it is mandated by federal or state law, and to probation and correctional facilities.<sup>247</sup> Of greatest interest are the provisions governing the disclosure of this information for the purposes of contact tracing. The legislation provides that:

a physician may disclose confidential HIV related information ... (1) to a contact or to a public health officer for the purpose of making the disclosure to said contact ... [if] (2) the physician reasonably believes disclosure is medically appropriate and there is a significant risk of infection to the contact; (3) the physician has counseled the protected individual regarding the need to notify the contact, and the physician reasonably believes the protected individual will not inform the contact; and (4) the physician has informed the protected individual of his or her intent to make such disclosure to a contact and has given the protected individual the opportunity to express a preference as to whether disclosure should be made by the physician directly or to a public health officer for the purpose of said disclosure.<sup>248</sup>

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<sup>243</sup>An Act to amend the Public Health Law, the Insurance Law and the Social Services Law in relation to testing for HIV and to the confidentiality of information and records related to HIV infection and AIDS, N.Y. C.L.S. Ch. 584 (1988) [hereinafter *New York Act*].

Similar contact tracing guidelines are in effect in Oregon and Maryland. See *AIDS: A Public Health Challenge*, *supra*, note 66 at 4-17.

<sup>244</sup>*New York Act*, *supra*, note 243, § 1, statement of legislative intent.

<sup>245</sup>*Ibid.*, § 2781.

<sup>246</sup>The New York legislation can be contrasted to the loosely drafted confidentiality provisions in the Ontario *Health Promotion and Protection Act*, *supra*, note 10. See the discussion above in Part II. The New York legislation governs all disclosure of HIV related information whereas the Ontario legislation only governs the disclosure of information relating to mandatory reports made under the Act. The New York legislation does not require the mandatory reporting of HIV infection and no state records of infected individuals are maintained. The legislation governs the release of all HIV related information obtained not only by the state, but by anyone, thus providing effective and comprehensive confidentiality guarantees.

<sup>247</sup>*New York Act*, *supra*, note 243, § 2782.

<sup>248</sup>*Ibid.*, § 2782 s.4. Unauthorized disclosure of confidential HIV related information is punishable with a fine of up to \$5,000 (§ 2783).

Although physicians are given the option to disclose this information, they are under no legal obligation to do so. The legislation protects physicians from any criminal or civil liability for failure to disclose HIV-related information to a contact; the physician is also protected from any liability for disclosing this information if "carried out in good faith and without malice".<sup>249</sup>

Both the New York legislation and the present Ontario contact tracing program emphasize that the most effective and least invasive contact tracing program is one conducted by the patient. In fact, over 90 per cent of HIV contact tracing in Ontario is performed by the patient, or his or her physician with the patient's consent, without any assistance from the Medical Officer of Health.<sup>250</sup> Physician-conducted contact tracing has already been proven successful in Ontario.

In order to further encourage voluntary HIV contact tracing, it may be desirable for public health officials to provide facilities to assist HIV-infected persons in performing contact tracing. Both the states of Minnesota and North Carolina have put into place HIV partner notification programs that provide HIV-infected persons with counselling on how to notify their partners.<sup>251</sup> Clients are also given the option to request that the Health Department notify their partners. Most importantly, these programs are voluntary and operate anonymously; HIV reporting is not required under

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<sup>249</sup>*Ibid.*, s.2783 s.3.

<sup>250</sup>See the discussion above in Part II.

<sup>251</sup>The State of Minnesota has initiated a "Partner Outreach Program" which offers seropositive individuals counselling sessions to teach them how and what to tell their partners. Counseling is done on an anonymous basis. Although the program is still in a formative stage, officials report that it appears to encourage participation and has generated a significant level of satisfaction among participants. If they choose, clients may opt out of the "personal contact plan" and request that the Health Department notify their partners. See *AIDS: A Public Health Challenge*, *supra*, note 66 at 3-41. A similar program is also presently in effect in North Carolina. HIV-infected persons are given the opportunity to participate in a specially designed "HIV Partner Notification Program". Clients have three options. They can: (1) meet with an HIV counsellor who will notify and counsel partners confidentially; (2) complete and mail to the AIDS Control Program a form identifying partners so that an HIV counsellor can notify partners; and (3) can notify partners themselves. See E. Blackenship *et al.*, "HIV Partner Notification within An Anonymous Testing System" (abstract) in *AIDS: The Scientific and Social Challenge*, V International Conference on AIDS at 743. Most importantly, the infected person may participate in the program anonymously. The results of the report submitted to the conference found that the preliminary data on the program "suggests cooperation by HIV-infected persons." The study also found that the "program encourages participation of HIV-infected persons by allowing them to maintain anonymity." The study concluded "that despite certain problems [such as the quality of information requested on the forms and the inability to notify partners of anonymously tested HIV-infected persons who do not return for test results], HIV partner notification can be effective in a system where HIV is not reportable and anonymity is maintained." [*Ibid.*]

either program. Programs like these illustrate that HIV contact tracing can be responsibly performed within a system that does not require mandatory reporting.

Obviously, the most difficult situation arises when a patient who presents a risk of contagion to unsuspecting third parties refuses to perform contact tracing and refuses to consent to contact tracing by his or her physician. Given that there is a compelling need to inform these third parties who are at a high risk of HIV infection, disclosure without the patient's consent in these exceptional circumstances is warranted. However, the central issue is whether all cases of HIV infection must be reported to the government in order to ensure that contact tracing will be performed in the relatively small number of cases where uncooperative patients continue to present a risk of infection and refuse to inform the parties at risk. Mandatory government reporting, because it raises legitimate fears of unwarranted or inadvertent disclosure, thereby discouraging HIV testing, carries a very high price. Instead, the primary obligation to perform contact tracing in these circumstances should rest with the physician, not the Medical Officer of Health.<sup>252</sup> This alternative effectively minimizes the risk of unwarranted disclosure of HIV-related information inherent in any mandatory reporting program, but at the same time ensures that third party contacts who are at risk will be informed.

Of course, the physician should always have the option of requesting the public health officer to perform the necessary contact tracing in the event the physician does not wish to perform the contact tracing personally. The New York legislation provides for such an alternative by permitting physicians to inform a public health officer of their patient's HIV status for the purposes of contact tracing.<sup>253</sup> The identity of the index person might also be easier to protect when the tracing is performed by a public health officer rather than a private physician.<sup>254</sup>

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<sup>252</sup>In the case of anonymous testing, such as that presently performed by the Hassle Free Clinic in Toronto (discussed above in Part II), it is likely that the physician responsible for the HIV test would not know the patient and would be unable to judge whether this patient presents a risk of infection to any third party. Physicians working at a walk-in and usually anonymous clinic such as the Hassle Free might be unlikely to develop a personal relationship with their patients which would enable them to assess this risk.

As a result, it is unlikely that contact tracing would be performed in this circumstance. However, the only alternative, the mandatory reporting of the name of the patient to the government, would subvert the entire basis for the anonymous setting of the clinic. Patients would be deterred from using the clinic, they would be unable to determine their HIV status, and a critical opportunity to counsel these individuals on how to prevent the risk of transmission would be lost.

<sup>253</sup>New York *Act, supra*, note 243, § 2782 s.4(a)(1).

<sup>254</sup>*Ibid.*, § 2782 s.4(a)(4) requires that the patient must be given the option of requesting that contact tracing be performed by the public health officer rather than the physician.

There is no reason to believe that physicians, if given the option to do so, will not responsibly exercise an obligation to initiate contact tracing to protect those who are unknowingly at risk if their patient refuses to do so. This responsibility is consistent with the many professional and legal obligations placed on physicians to disclose information in order to prevent imminent harm to others, such as the obligation on physicians to report to the Registrar of Motor Vehicles the names of patients who have medical conditions that may make it dangerous for them to drive.<sup>255</sup> Physicians have also expressed their willingness to assume an obligation to perform HIV contact tracing: notwithstanding the fact that at present Ontario physicians are not permitted to disclose HIV-related information to anyone other than the Medical Officer of Health, the Canadian Medical Association recently voted that physicians should, in exceptional circumstances of risk to third parties, be allowed to violate patient confidentiality and inform the sexual partners of seropositive patients.<sup>256</sup>

It is likely unnecessary that physicians should be under a legal obligation to perform contact tracing, as it is reasonable to assume that they would fulfill their professional responsibility to inform parties at risk. The New York legislation thus immunizes physicians from any liability for failure to disclose HIV-related information, thereby ensuring that physicians will not be pressured into unwarranted disclosure by fears of potential liability.<sup>257</sup>

However, in order to ensure physician compliance, it is possible that they could be subject to some form of civil or statutory liability for failure to inform parties at risk. For example, in the United States, a health care professional's civil liability for "failure to warn" third parties at risk was first developed in *Tarasoff v. Regents of the University of California*, a decision of the California Supreme Court which found a psychologist liable for failure to warn a third party of his patient's intention to murder her.<sup>258</sup> As a result of this decision, under certain circumstances health care professionals in the United States may be liable for failure to disclose confidential patient information to those who are in foreseeable danger of serious harm

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<sup>255</sup>*Highway Traffic Act*, *supra*, note 69. It might also be useful to provide some compensation for physicians who engage in contact tracing; the government could consider contact tracing as a billable service under the Ontario Health Insurance Plan.

<sup>256</sup>See *AIDS Policy and Law*, vol.2, No. 17 (9 September 1987) at 4.

<sup>257</sup>*New York Act*, *supra*, note 243, § 2783 s.3(a). But see Note, "Confidentiality, Warning, and AIDS: A Proposal to Protect Patients, Third Parties, and Physicians" (1988) 4 *Touro L. Rev.* 301 where the author argues that the New York legislation "fails to establish any sincere notification program" because the legislation relieves the physician of any legal duty to warn third parties [at 323-6].

<sup>258</sup>17 Cal. 3d 425, 551 P.2d 410 (1976).

from their patients. It has been suggested that physicians may thus be under a "duty to warn" contacts of seropositive patients.<sup>259</sup>

At present, there is no Canadian equivalent to the physician's "duty to warn" as it has developed in the United States. Although the physician is required to disclose HIV-related information to the Medical Officer of Health, disclosure of confidential medical information to any other party, even those at risk for HIV infection, would likely constitute professional misconduct.<sup>260</sup> Of course, the great advantage of this scheme, at least from the physician's point of view, is that his or her legal responsibility is entirely unambiguous. Once it is recognized that physicians should have the primary obligation to initiate contact tracing, they could be faced with uncertainties about their duties to their patient and to third parties, when their patient refuses to provide reasonable assurances that relevant third parties will be informed. It would be desirable to provide physicians with some specific guidance about when disclosure is necessary and, of course, it would be essential that they be protected from liability for disclosing this information.<sup>261</sup> Although this point is debatable, it may even be necessary to impose liability on physicians for failure to do so.

Rather than a scheme of mandatory reporting and state-supervised contact tracing, leaving the primary responsibility to perform contact tracing with the physician provides an equally effective and far less intrusive means to ensure that contact tracing, where appropriate, is performed. In short, the Ontario law on this point, which forbids physician disclosure, is entirely at odds with a responsible public health response to HIV contact tracing.

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<sup>259</sup>See L. Gostin and W. Curran, "AIDS Screening, Confidentiality, and the Duty to Warn" (1987) 77 Am. J. Public Health 361 at 364; A. Peter and H. Sanchez, "The Therapist's Duty to Disclose Communicable Diseases" (1987) 14 West. State Univ. L. Rev. 465 at 475; and H. Rosencranz & W. Lavey, "Treating Patients with Communicable Diseases: Limiting Liability for Physicians and Safeguarding the Public Health" (1987) 32 St. Louis Univ. L. Rev. 75 at 88.

<sup>260</sup>See the discussion above in Part II, and G. Sharpe, *The Law and Medicine in Canada*, *supra*, note 69 at 181-2. See also, D.G. Casswell, "Disclosure by a Physician of AIDS-related Patient Information: An Ethical and Legal Dilemma", *supra*, note 65 at 246 where the author concludes that "what little relevant case authority there is provides no clear guidance whether a physician owes a duty to warn a partner who may be at risk of HIV infection by his or her patient."

<sup>261</sup>Note, "Contact Tracing for HIV Infection: A Plea for Privacy" (1988) 20 Colum. Hu. Rts. L. Rev. 157. The author argues that the legislature should enact a statutory regime to govern the confidentiality of HIV-related information, given that the traditional legislative scheme governing the control of infectious diseases (involving mandatory reporting as its central feature) is not an effective way to address the problem of HIV transmission. After discussing confidentiality legislation for HIV-related information, the author concludes that it may also be necessary to impose some legal obligation upon physicians in order to ensure that they perform contact tracing where appropriate.

The central question thus posed by the two alternative contact tracing programs outlined above is whether the primary responsibility to initiate contact tracing should rest with the physician or with the Medical Officer of Health, and this is precisely the issue raised in the recent prosecution mentioned above of a Toronto physician who has refused to report the name of one of his patients who is seropositive. Although the facts of this particular case have not yet been revealed, it is possible that the physician in question has counselled his patient on the risk of HIV transmission, and the patient has taken all appropriate precautions to avoid any risk of infection. It is also possible that given the past sexual history between the patient and his wife, the physician is confident that the patient's wife has not been exposed to HIV (for example, the couple may have used condoms or may not have had sexual relations since the husband's infection). If the physician is confident that disclosure is not medically appropriate because there is not a significant risk of infection to a contact, he would be justified in deciding not to perform contact tracing. No doubt, the physician is acutely aware of the potentially devastating effect that revealing this information could have on his patient's marriage, as well as the potential HIV-related discrimination that could result if this information should reach employers, insurers or landlords.<sup>262</sup> Unless circumstances compel disclosure, the patient should be entitled to keep his HIV status confidential.

The Ministry, presumably without any knowledge of the facts of the case, refuses to accept the physician's judgment that contact tracing is inappropriate in this case. The Ministry is thus insisting on informing the wife of her husband's HIV status and is seeking to enforce compliance with the *Health Promotion and Protection Act* which requires that physicians report the names of all their HIV-infected patients to the government. It is likely that the Ministry is aggressively pursuing contact tracing because, unlike the physician in question, it believes that the patient's wife is at a significant risk of acquiring or transmitting HIV. For example, should she decide to become pregnant or engage in sexual intercourse with another party, if she is unaware that she may be HIV-infected, she could inadvertently transmit HIV to her child or sex partner. As discussed above, if there

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<sup>262</sup>One example of AIDS-related discrimination that may be of particular concern to the patient in this case is the possibility that in the event of a divorce, his wife could argue that he should be denied access to his children because he is seropositive. This issue has recently been raised in *Re B* (1 March 1988) York S.C. 106402-84 (Ont. H.C.) (see T. Ducharme, "Preparing for a Legal Epidemic", *supra*, note 6 at 497). In another recent case in Quebec, a mother of two children unsuccessfully argued before the Superior Court that her former husband should be denied any access to their children because he is seropositive. The Court rejected the argument, noting that there was no risk of HIV transmission in normal family contacts. See *Droit de la famille-663* (18 April 1989), Montréal 500-12-165160-874, J.E. 89-947 (C.S.).

is a significant risk of HIV transmission, contact tracing may be appropriate, notwithstanding the considerable cost this may impose on the husband.

The critical issue, of course, is who should decide whether contact tracing is appropriate. The first option, a mandatory reporting scheme, ensures that this decision will rest with the Medical Officer of Health. The second option, a physician-conducted contact tracing scheme as enacted in New York State, places the responsibility on the physician. Because of legitimate fears of unwarranted disclosure, the first option seriously impairs a s. 15 interest and critically impedes the early detection of HIV infection. The second option presents a much smaller threat of unwarranted disclosure, but at the same time ensures that when the circumstances compel disclosure, contact tracing will be performed.

Finally, in order to ensure that contact tracing will be performed, rather than imposing a scheme of mandatory reporting and state-supervised contact tracing, if necessary it would be preferable to place some tortious or statutory obligation upon physicians requiring them to perform contact tracing where warranted. In short, this second option—which focusses primarily on facilitating voluntary contact tracing, and in the relatively rare circumstances where a patient refuses to consent to contact tracing, permits (or may even require) physician disclosure—illustrates that contact tracing can be effectively accomplished in a system in which HIV infection is not reported to public health authorities. The unique conditions of the HIV epidemic make it essential that we devise and adopt a public health program that provides maximum guarantees of confidentiality and, at the same time, permits disclosure of HIV-related information where circumstances warrant. The physician-conducted contact tracing option outlined above much more effectively addresses these two vital concerns.

Once it has been established that a physician-conducted contact tracing scheme, such as that enacted in New York State, much less seriously impairs a s. 15 interest and is a more responsible and effective public health response to the AIDS epidemic, it cannot be concluded that the Ontario program can withstand the proportionality test under s. 1.

### *E. Conclusion*

The deleterious effect of an HIV mandatory reporting and contact tracing scheme has been described in detail. Seropositive individuals, because they reasonably constitute a class of the physically disabled or a discrete and insular minority under s. 15 of the *Charter*, are entitled to challenge legislation that prejudicially affects them. There can be no question that the mandatory reporting of HIV infection with identifiers and state-supervised contact tracing, because it presents the risk of unwarranted disclosure of

HIV-related information which can result in highly damaging HIV-related discrimination, prejudicially affects the interests of seropositive individuals, thereby shifting the burden to the state to establish that this program is demonstrably justified.

The government cannot successfully establish that its legislative program, which has the effect of discouraging voluntary HIV testing, a critical aspect of disease control, furthers the legitimate public health objective of preventing the spread of HIV. Nor can the government successfully establish that a state-supervised contact tracing program is an acceptable violation of the interests of seropositive individuals, given that a much less invasive alternative is available: physician-conducted contact tracing. The mandatory reporting requirements of the Ontario *Health Protection and Promotion Act* cannot therefore reasonably withstand a *Charter* challenge.

A highly aggressive public health response to the AIDS crisis is not necessarily one that will best protect public health, and, in fact, it could possibly be one of the least effective responses to this complex and acute social crisis. Yet invasive measures have a particular appeal when faced with a disturbing, mysterious, and devastating disease which our ancient fears of contagion and death have surrounded with myth and metaphor. Once complicated by its route of sexual transmission, which to date has largely been homosexual, and its intersection with class, now that the disease is ravaging the underclass of the IV drug user, it becomes more and more difficult to sketch a responsible public health response to so complex a social phenomenon. Nonetheless, the Government of Ontario has not yet struck an acceptable balance between the interests of people with HIV disease and the imperatives of disease control. Nothing less than the public health of its citizens is at stake.

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