

Aids and the Law: Problems with the Ontario Health Protection and Promotion Act, 1983 — A Physician's Perspective

Philip B. BERGER*

INTRODUCTION	181
I. REPORTING OF HIV INFECTED PERSONS	181
A. Physician Reporting Requirements	181
B. Nominal Testing	182
1. Partner Notification or Contact Tracing	182
2. Data Collection	183
3. Follow-up	183
C. Physician Non-compliance	184
D. Unequal Enforcement	185
II. MEDICAL OFFICER OF HEALTH ORDERS AGAINST PERSONS WITH COMMUNICABLE DISEASES	186
A. Medical Officer of Health Authority	187
B. Unequal Enforcement	187
C. Inconsistent Application and Impossibility of Enforcement	188
D. Lack of Due Process	188
III. VIRULENT DISEASE DESIGNATION: HOSPITAL DETENTION	189
CONCLUSION	192
APPENDIX	193

* Doctor, Toronto, Ontario.

The *Health Protection and Promotion Act, 1983*¹ is the legislation governing public health activities in the province of Ontario. Section 2 of the *Act* sets out its purpose: "to provide for the organization and delivery of public health programs and services, the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario."

The *Act* defines the authority of a Medical Officer of Health (MOH) and the responsibilities of practicing physicians with respect to infectious diseases. Infectious diseases are classified into three categories: reportable diseases, communicable diseases and virulent diseases. Reportable and communicable diseases are specified in regulations made under the *Act*. The *Act* lists twelve virulent diseases and others can be added by regulation. The powers of the Medical Officers of Health flow from the legal designation of a disease as communicable or virulent. Under the regulations of the *Act*, Acquired Immunodeficiency Syndrome (AIDS) has been designated as a communicable disease and as a reportable disease.² AIDS has not been classified as a virulent disease. Indeed, no infectious disease has been designated as virulent since the *Act* was proclaimed.

This paper will examine the *Act* with respect to AIDS in the areas of physician reporting of Human Immunodeficiency Virus (HIV) infected persons, MOH orders against HIV infected persons and the different MOH powers attached to diseases designated as communicable and virulent.

I. REPORTING OF HIV INFECTED PERSONS

A. Physician Reporting Requirements

Pursuant to Sections 25 and 26 of the *Act*, a physician who "forms the opinion that the person has or may have a reportable disease" or "is or may be infected with an agent of a communicable disease" must report to the MOH of the health unit in which the physician works.³

-
1. *Health Protection and Promotion Act, 1983*, S.O. 1983, c. 10 [hereinafter the *Act* or the HPPA].
 2. Regulation 161/84 of the *Act* designates Acquired Immunodeficiency Syndrome (AIDS) as a communicable disease and Regulation 162/84 designates AIDS as a reportable disease.
 3. "25. A physician or a person registered under Part II, IV, V or VI of the *Health Disciplines Act* to practise a health discipline or a person registered as a drugless practitioner under the *Drugless Practitioners Act* who, while providing professional services to a person who is not a patient in or an out-patient of a hospital, forms the opinion that the person has or may have a reportable disease shall, as soon as possible after forming the opinion, report thereon to the medical officer of health of the health unit in which the professional services are provided. (*Supra* note 1, s. 25.)
 26. A physician who, while providing professional services to a person, forms the opinion that the person is or may be infected with an agent of a communicable disease shall, as soon as possible after forming the opinion, report thereon to the medical officer of health of the health unit in which the professional services are provided." (*Supra* note 1, s. 26.)

The regulations detail the information required for reporting of individuals with AIDS,⁴ and require that the reporting physician shall identify an individual and provide any further information that the MOH considers necessary.⁵

The Ontario Ministry of Health and the Ontario College of Physicians and Surgeons have concluded that HIV is the "agent of a communicable disease" (i.e., AIDS) as described in Section 26 of the *Act*. This is true according to all scientifically known information — HIV is the agent of AIDS. Therefore, the *Act* and its regulations require that physicians report the identity of all HIV infected persons to the local MOH.

Further, the *Act* obliges treating physicians to report the identity of a patient with a communicable disease who does not follow treatment recommendations in a fashion that satisfies the physician.⁶

B. Nominal Testing

The mandatory requirement that physicians report the name (and other information) to MOHs is called nominal testing. Nominal testing has three traditional public health purposes: partner notification (known as contact tracing) of all patients infected with HIV; collection of accurate epidemiological data without duplication (one infected person being tested more than once and therefore registering as more than one positive case report); and, ensuring the appropriate care of patients and their infected contacts.

1. Partner Notification or Contact Tracing

Tracing of sexual and other contacts of HIV infected persons requires the identity and co-operation of the infected person. Contact tracing presumes that persons being tested provide their real names to doctors and clinics. In a Colorado study that argued that reporting

4. Regulation 490/85 section 3 of the HPPA.

5. Ontario Regulation 490/85 sections 1(1) and (2) of the HPPA.

6. "34. (1) Every physician shall report to the medical officer of health the name and residence address of any person who is under the care and treatment of the physician in respect of a communicable disease and who refuses or neglects to continue the treatment in a manner and to a degree satisfactory to the physician.

(2) A report under subsection (1) shall be made to the medical officer of health serving the health unit in which the physician provided the care and treatment.

(3) Where the person does not reside in the health unit served by the medical officer of health mentioned in subsection (2), the medical officer of health shall transmit the report to the medical officer of health serving the health unit in which the person resides.

(4) A physician who makes a report under subsection (1) shall report to the medical officer of health at such times as are prescribed by the regulations any additional information prescribed by the regulations." (*Supra* note 1, s.34.)

did not deter gay men from being tested, thirty percent of those tested used pseudonyms. Partner notification requires a complete and honest naming of contacts by the infected person. It depends on the infected person's knowledge and memory of all names of every sexual and intravenous drug contact since 1978. Contacts must be found and, once located, counselled and tested. Preliminary studies from several American states report a contact location rate of 50 to 80 per cent. Not all those located agree to be tested. Contact tracing, where it occurs, consumes tremendous professional and financial resources. It is most successful in particular clinical settings and social climates where patients are co-operative in naming contacts who are easily found by public health officials.

Because of the prolonged period between the date of infection and the diagnosis of infection in AIDS, probably in the order of four to five years, and because of the mobility of contacts in high-prevalence urban settings, information on sexual partners when available is likely outdated.

Contact tracing as a control strategy for HIV infection is less certain than for diseases for which curative therapies are available. The only intervention currently available to interrupt HIV transmission is counselling behaviour change. Counselling does not guarantee interruption in transmission of HIV disease in the same way penicillin does for gonorrhoea.

Contact tracing is labour-intensive and expensive. The June 24, 1988 *Journal of the American Medical Association* reported a cost of \$6,500 for contact tracing of one HIV-infected man in rural South Carolina. If public health authorities attempted to trace all sexual and needle-sharing contacts of HIV infected persons in Toronto, the cost would prohibit all other prevention and education activities.

2. Data Collection

Public health officials argue that anonymous testing and non-nominal testing could give rise to more than one positive result being generated by one person through repeated testing. Patients would have no reason to withhold results of previous testing if repeat testing were unconditionally available. Duplication in counting HIV cases could be avoided if patients had unimpeded access to repeat testing and if patients were specifically asked about previous test results. Far more sensitive information about sexuality and drug use is already provided by patients, the results being used to compile public health department statistics. As it stands now, infected persons who refuse testing for fear of being reported are not registered at all in department figures of HIV prevalence.

3. Follow-up

Public health authorities argue that mandatory nominal reporting permits follow-up to ensure that patients are receiving proper medical care. Persons tested under any system can be informed of treatment possibilities as part of pre-test counselling. Those testing positive

could be provided with the names of physicians familiar with HIV disease. Appropriate care for persons testing HIV positive could also be ensured through educational support for physicians caring for HIV infected patients.

In Ontario, HIV antibody testing became available through the central provincial laboratory in November, 1985. To protect the identity of persons for whom the test was ordered, Ontario government policy permitted tests to be ordered by physicians and clinics using patient initials or code numbers on blood tubes and laboratory requisition slips. The government expected that physicians would report the identity of those patients who tested HIV positive, as required by law.

Section 29 of the *Act* requires the laboratory to report to the MOH "each case of a positive laboratory finding in respect of a reportable disease". These reports are made whether the patient is identified to the laboratory by name or code. Thus the province can track the number of persons testing HIV positive even if patient identifiers were not provided to the laboratory.

C. Physician Non-compliance

As soon as HIV antibody testing became available, in November 1985, a controversy arose over reporting the names of HIV infected persons to local MOHs. In Toronto, which accounts for 60 to 70 per cent of Ontario's reported AIDS cases and HIV positive laboratory results, private physicians with large gay practices refused to provide the identities of their patients who tested positive. These physicians believed that many high-risk individuals would avoid testing for fear of their names being reported to the government. These high-risk individuals (with most to lose personally by identification) would not come forward for testing and counselling unless their names were withheld from provincial health authorities. Although the scientific evidence may be imperfect according to some, the reports available indicate that the premise holds.

In this type of non-nominal HIV testing, the physicians knew the identities of their patients testing positive but did not provide the patients' names to public health authorities. The physicians ordered the tests using untraceable codes such as numbers or reversed initials of their patients' names. No identifying data such as birthdate or address were written on the laboratory slip. And no identifying data were reported to local public health officials for patients who tested positive.

Non-nominal testing contravenes Section 26 of the *Act*. But despite initial public and private pressure on physicians, the Toronto Department of Public Health has never compelled a physician to provide the name of an HIV infected person.

Meanwhile, Canada's busiest sexually transmitted disease clinic, Toronto's Hassle Free Clinic, began its anonymous HIV testing program in November, 1985. Anonymous testing means that people seeking an HIV test do not identify themselves to the testing site. They are assigned a unique code number and retrieve the result by presenting the number to clinic staff. The HIV test at Hassle Free Clinic is ordered under the name of a staff physician. Clinic staff and doctors never know the identity of a person testing positive.

Physicians associated with the Hassle Free Clinic are unable to comply with the mandatory reporting requirements of Section 26 of the *Act*. Hassle Free Clinic advertises its services and even had a scientific poster on its program accepted at the VI International Conference on AIDS in June, 1990 in San Francisco. Hassle Free Clinic physicians have never been challenged by the Toronto Department of Public Health. (It is worth pointing out that under both non-nominal and anonymous testing systems, persons testing HIV positive can still provide the names of their contacts.)

Finally, physicians with large numbers of HIV infected patients do not report in any fashion patients who fail to comply with treatment standards set by physicians — a reporting requirement demanded by Section 34 of the *Act*. An example of a patient who refuses to continue treatment "satisfactory to the physician" is the HIV infected patient who continues to practice unsafe sex. Physicians routinely counsel patients to practice safe sex and instruct patients on methods to prevent HIV transmission to others.

If an HIV infected patient were to contract another sexually transmitted disease such as gonorrhea, the physician would have solid evidence that the patient is practicing unsafe sex, since the only way to contract gonorrhea is through unsafe sex. Therefore, HIV infected patients who do contract gonorrhea are not abiding by their physicians' treatment recommendations. Such patients place others at peril of HIV infections. Yet no physician that I know routinely reports the names and addresses of such patients, as required by Section 34.

D. Unequal Enforcement

For the past several years the Ministry of Health has quietly permitted non-nominal testing. Although a policy of non-nominal testing has never been publicly declared, physicians who choose to contravene the Section 26 reporting requirements now feel secure in the knowledge that non-compliance will not lead to prosecution under the *Act*.

The province's failure to enforce the *Act* has changed the mandatory reporting requirements under law to discretionary reporting by physicians in practice and to inconsistency in enforcement across Ontario's public health units.

While, as a matter of policy, Toronto's Department of Public Health does not require physicians to report names of patients who test HIV positive, local MOHs in most other Ontario public health units do. Physicians in other health units usually comply with the requirements to provide names partly out of ignorance of the provincial policy and partly due to pressure from local MOHs. Further, most of these physicians are unaware that HIV tests can be ordered without identifying the patients. Their patients' names are recorded on the blood tube and laboratory requisition that is submitted to the central provincial laboratory. The laboratory then provides the HIV positive result, with name, to the MOH of the unit in which the physician practices.

Section 32 of the *Act* compels MOH who receives a report on a person not residing in the unit served by that MOH to report to the MOH of the unit in which the person resides.⁷ Yet HIV infected Ontario citizens who wish to protect their identities from provincial health authorities need only connect with the Toronto physicians familiar with non-nominal testing. They could also be tested through the widely publicized anonymous testing program of Hassle Free Clinic. Both non-nominal and anonymous testing prevent Toronto MOHs from reporting by name persons living outside of Toronto who test HIV positive at sites located within the Toronto public health unit. Ontario citizens (outside of Toronto) who are unable to make the connections and are tested locally will find their names registered with public health departments.

Failure to enforce the *Act* also occurs between local public health units and the Public Health Branch of the Ministry of Health. The regulations require local MOHs to forward copies of reports on HIV to the Ministry.⁸ They do not provide for the deletion of names from HIV/AIDS reports forwarded to the Ministry.⁹ Yet, in the past year the Ministry has terminated the requirement for MOHs to forward names to Ministry staff, in contravention of the regulation.

II. MEDICAL OFFICER OF HEALTH ORDERS AGAINST PERSONS WITH COMMUNICABLE DISEASES

The second area of concern with the *Act* is the manner in which MOHs issue orders against persons with HIV.

7. "32. (1) A medical officer of health may transmit to another medical officer of health or to the proper public health official in another jurisdiction any information in respect of a person in relation to whom a report in respect of a reportable disease has been made under this Act.

(2) Where the person in respect of whom a report is made under this Part to a medical officer of health does not reside in the health unit served by the medical officer of health, the medical officer of health shall transmit the report to the medical officer of health serving the health unit in which the person resides." (*Supra* note 1, s. 32)

8. Ontario Regulation 490/85 Section 6 of the HPPA:

"6 (1) Where a medical officer of health receives a report made under section 25, 26, 27 or 28, subsection 29(2) or section 30, he shall forward a copy of the report to the Public Health Branch of the Ministry."

9. Ontario Regulation 490/85. Section 6(2) of the HPPA.

A. Medical Officer of Health Authority

Section 22 of the *Act* describes the circumstances in which MOH can issue orders and the powers the MOH may exercise when making an order against a person with a communicable disease:

22 (1) A medical officer of health, in the circumstances mentioned in subsection (2), by a written order may require a person to take or to refrain from taking any action that is specified in the order in respect of a communicable disease.

(2) A medical officer of health may make an order under this section where he is of the opinion upon reasonable and probable grounds,

(a) that a communicable disease exists or may exist or that there is an immediate risk of an outbreak of a communicable disease in the health unit served by the medical officer of health;

(b) that the communicable disease presents a risk to the health of persons in the health unit served by the medical officer of health; and

(c) that the requirements specified in the order are necessary in order to decrease or eliminate the risk to health presented by the communicable disease.

Section 22 is open-ended and imprecise. Section 7 of the *Act* permits the Minister to publish guidelines for the provisions of mandatory health programs and services, but no such guidelines have been issued.¹⁰ Under Section 5 of the *Act*, "mandatory health programs" include the "control of communicable diseases".

B. Unequal Enforcement

The unequal enforcement of Section 26 (physician reporting requirements) automatically produces unequal application of Section 22. It is impossible for a local MOH (mostly in the City of Toronto) who does not know the identity of an HIV infected person to issue a Section 22 order. Non-nominal and anonymous testing thus preclude any action by provincial health authorities. If you do not know the name, you cannot monitor an individual, nor can you issue an order.

This inequality is reflected in the number of orders issued by public health units. The City of Toronto has about eight times the number of reported AIDS cases as the Regional

10. "7 (1) The Minister may publish guidelines for the provision of mandatory health programs and services and every board of health shall comply with the published guidelines.

(2) Guidelines shall be transmitted to each board of health and shall be available for public inspection in the Ministry." (*Supra* note 1, s. 7.)

Municipality of Ottawa-Carleton. Over the past year, the City of Toronto Department of Public Health has issued no Section 22 orders. An MOH for the Ottawa-Carleton region is on record as issuing several Section 22 orders.

C. Inconsistent Application and Impossibility of Enforcement

Appendix A includes an example of a Section 22 Order issued against an HIV infected person. This Order has been issued in the absence of any standards or guidelines under the *Act*. The failure of the Minister to provide guidelines leaves individual MOHs free to make their own subjective judgments about what constitutes risky behaviour. The manner in which people should conduct themselves so as not to infect others (Section 22(4)(h)) is a matter of debate in public health circles. A Toronto Department of Public Health background document on the *Act* (March 12, 1990) states that "MOH may specify in an order that [...] insertive intercourse not occur or that it not occur without a condom". But the Toronto document could not specify what the order should be: no intercourse? or no intercourse without a condom? The Order reproduced in Appendix A (from a different health unit) is quite definite about prohibiting any form of insertive intercourse.

However, the first three parts of this order are unenforceable. How is the MOH to monitor the sexual activities of the person? How is the MOH to ensure that the person is not sharing drug using equipment? And how is the MOH to compel the person to provide the names of all sexual and needle sharing contacts (if indeed the person knows or remembers the names of these contacts)? No government can monitor activities of a person known to be HIV infected for 24 hours a day. The best protection is to adopt safe sex and needle use guidelines. Coercive action to control the spread of HIV is doomed to failure by the very private behaviours that promote HIV transmission.

D. Lack of Due Process

Section 22 Orders deprive persons against whom they are issued of certain traditional fundamental rights. No notice is required prior to the Order being issued against an HIV infected person. The person is not provided with the prior right to counsel; the person is not allowed to examine the evidence against him/her, nor to cross-examine on the evidence. There is no right to a judicial hearing prior to the Order being issued.¹¹ The Order takes effect immediately upon service on the person to whom it is directed unless a stay is granted. Only at that stage can the Order be appealed under section 43 to the Health Protection

11. "91. The Minister, the Chief Medical Officer of Health, a medical officer of health or a public health inspector need not hold or afford to any person an opportunity for a hearing before making an order or giving directions under this Act." (*Supra* note 1, s. 91.)

Appeal Board, and a hearing may be required.¹² A stay of the Order is at the discretion of the Board.

The exercise of the powers under Section 22 depends on the personal inclinations of MOH working in different health units. Finally, the use of Section 22 depends on where a citizen lives or on the manner in which he/she was tested (nominal, non-nominal or anonymous). Therefore, the application of Section 22 of the *Act* is characterized by subjectivity, inequality and inconsistency.

III. VIRULENT DISEASE DESIGNATION: HOSPITAL DETENTION

The third area of concern is the notion of designating HIV/AIDS as a virulent disease. Section 96 of the *Act* states that "The Minister may make regulations specifying diseases as communicable diseases, reportable diseases and virulent diseases for the purposes of this *Act*." In Ontario, HIV/AIDS is now classified as a reportable and communicable disease. However, in January, 1990 the Chief MOH of Ontario requested that the Minister specify HIV/AIDS as a virulent disease.

If HIV/AIDS were classified as a virulent disease, such a designation would permit compulsory hospital admission and detention of certain HIV infected persons under section 35 of the *Act*.¹³ At present, section 35 can only be

12. "43.(1) An order by a medical officer of health or a public health inspector under this Act shall inform the person to whom it is directed that the person is entitled to a hearing by the Board if he mails or delivers to the medical officer of health or public health inspector, as the case requires, and to the Board, within fifteen days after a copy of the order is served on him, notice in writing requiring a hearing and he may also require such a hearing." (*Supra* note 1, s. 43.)

13. "35. (1) Upon application by a medical officer of health, a provincial offences court, in the circumstances specified in subsection (2), may make an order in the terms specified in subsection (3).

(2) An order may be made under subsection (3) where a person has failed to comply with an order by a medical officer of health in respect of a communicable disease that is a virulent disease,

(a) that the person isolate himself and remain in isolation from other persons;

(b) that the person submit to an examination by a physician;

(c) that the person place himself under the care and treatment of a physician; or

(d) that the person conduct himself in such a manner as not to expose another person to infection.

(3) In an order under this section a provincial offences court may order that the person who has failed to comply with the order of the medical officer of health,

(a) be taken into custody and be admitted to and detained in a hospital named in the order;

(b) be examined by a physician to ascertain whether or not the person is infected with an agent of a virulent disease; and

(c) if found on examination to be infected with an agent of a virulent disease, be treated for the

used for communicable diseases that are not virulent if a section 22(4)(c) isolation Order is breached.¹⁴

The nature of HIV transmission does not justify an isolation Order. HIV is not spread by casual contact in the way that other virulent diseases are spread. Even the most aggressive MOHs would be hard-pressed to justify on scientific grounds making an isolation Order against an HIV infected person. However, the Chief MOH believes that for a few individuals, detention and treatment in a hospital for up to four months on a renewable basis is necessary for prevention of HIV transmission. Section 36 could never be invoked if isolation Orders were not issued, so virulent classification of HIV is another option.

The type of individual who worries the Chief MOH is the one who fails to comply with section 35(2)(d) — the person who fails to "conduct himself in such a manner as not to expose another person to infection", contrary to section 35(2)(d) of the *Act*. But as with Section 22 Orders, no guidelines for establishing non-compliance exist. How is the MOH to monitor and measure the conduct? What are the criteria for failure to conduct oneself properly? Are the criteria reasonable and scientifically sound? No answers are forthcoming because no guidelines exist.

The Chief MOH's January, 1990 request to designate HIV/AIDS as virulent is strange in other respects. Public health officials have always argued that HIV and AIDS should not be treated differently from other infectious diseases. Yet they are now singling out AIDS for classification as a virulent disease without consideration of other infectious diseases that should qualify equally for this category. For example, Hepatitis B, Hepatitis C, non-A non-B Hepatitis and HIV-2 are all transmitted in a similar way to HIV. They are all disease-producing and they can lead to death. To pick on AIDS is discriminatory and stigmatizes those with HIV infection.

The Chief MOH makes no distinction between HIV or other infections already classified as virulent. Some of the virulent diseases listed in the *Act* are contagious for a limited period of time — after several weeks of isolation, infected persons can no longer spread the disease. The other diseases listed are not contagious after proper treatment. The AIDS virus is always contagious and treatment does not prevent transmission. To achieve the same guarantee of public protection possible for the other virulent diseases, HIV infected people would have to be detained for life — the only means to ensure that HIV is not

disease." (*Supra* note 1, s. 35.)

14. If a person does not comply with an isolation Order for a communicable disease, then Section 36 permits a Medical Officer of Health to apply Section 35:

"36. (1) Where a medical officer of health has made an order in respect of a communicable disease that is a virulent disease requiring a person to place himself under the care and treatment of a physician or to take other action specified in the order and the person withdraws from the care and treatment or fails to continue the specified action, section 35 applies with necessary modifications and for the purpose, the person shall be deemed to have failed to comply with an order of the medical officer of health.

(2) Where a person who is infected with an agent of a communicable disease has failed to comply with an order by a medical officer of health that the person isolate himself and remain in isolation from other persons, section 35 applies with necessary modifications." (*Supra* note 1, s. 36.)

transmitted sexually or by needle sharing. Time and treatment provide the guarantee for other virulent diseases — only lifetime detention can for HIV.

MOHs and others (including the Canadian Bar Association Ontario Committee to study the legal implications of AIDS, April 1986) claim that psychotherapy, counselling and behaviour modification (in hospitals using Section 35) constitute the public health intervention to prevent the deliberate spread of HIV. Yet no evidence in the medical literature supports this contention. Compulsory therapy for individuals unwilling to behave responsibly is notoriously unsuccessful. Some MOHs argue that HIV infected individuals with mental illnesses are unable to behave responsibly and as such require treatment. If such persons exist, the treatment should properly occur under Ontario's *Mental Health Act*¹⁵ — an Act with many more safeguards to protect the rights of individuals.

Further, under Section 35(13), the MOH must satisfy himself that the person's release from hospital would not present a risk to others. This is an impossible task. How is the MOH to predict the future behaviour of individuals detained in hospital? No therapy or treatment of any kind can guarantee or assure to a reasonable extent that HIV infected persons will not deliberately or unintentionally (through mental illness) infect others. Only lifetime detention could produce an opinion that the HIV infected person would not present a risk to others.

Finally, the inequality of Section 26 enforcement (reporting requirements) ensures that Section 35 would be applied unequally. Because names are not routinely collected in Toronto, the likelihood of being subject to any Order in Toronto is much less than if one lived elsewhere. HIV infected persons tested non-nominally or anonymously would unlikely be subject to the provisions of Section 35.

Even if AIDS were not classified as a virulent disease, the *Act* still gives the province enormous power to intervene and protect the public if a Section 22 MOH Order is contravened for a communicable disease. Under Sections 99 and 100, a person who breaches an Order to refrain from sexual intercourse is guilty of an offence and liable to a \$5,000 per day fine. Further, under Section 101, the local or Chief MOH or Minister may apply to the Supreme Court for a judicial order prohibiting the person from contravening the Order not to have intercourse. Breach of the judicial order could result in detention of a person deliberately spreading HIV.

Sections 99 to 101 have never been tested in the courts for persons with HIV/AIDS. The failure of Ontario public health officials to use these sections does not justify increasing their powers by classifying AIDS as a virulent disease.

To complete the picture, the other means of protecting the public should be mentioned. One is the *Mental Health Act*¹⁶ for persons with mental disorders that result in the non-deliberate spread of HIV. The other is the *Criminal Code*¹⁷ for persons who

15. R.S.O. 1980, c. 262.

16. *Ibid.*

17. R.S.C. (1985), c. C-46 as am. by R.S.C. (1985), c. 2 (1st suppl.).

knowingly, in a show of anti-social behaviour, spread HIV. There is no need to add yet another option for detention under the virulent disease classification.

CONCLUSION

When the *Act* was drafted, the legal implications of AIDS were unknown. The *Act* has since proved unenforceable and unworkable in achieving the purpose of protecting the public from HIV. MOHs apply provisions of the *Act* inconsistently and enforce requirements of the *Act* unequally. No guidelines exist to ensure the uniform exercise of MOH powers. Physicians fail to comply with the *Act's* reporting requirements and do so with the tacit permission of provincial health authorities. The *Act* provides only an illusion of safety to an unwary public.

Lawmakers, scientists and medical experts should join together to formulate policy that could offer reasonable protection to the public from HIV. Public health legislation should be determined using the best available scientific evidence. The law reform process must be engaged to amend the *Act*. Physicians, MOHs and the public at large should be confident we have the best possible legislation to ensure public safety while protecting the rights of individuals infected with HIV. Only then will the *Act* be equitably enforced and truly respected by all sectors of society.

APPENDIX

ORDER OF MEDICAL OFFICER OF HEALTH

UNDER SECTION 22

HEALTH PROTECTION AND PROMOTION ACT, 1983

TO: _____

Name of Person, First Name

Address

City, Province Postal Code

ORDER

I am of the opinion, on reasonable and probable grounds that:

- (a) Based on the results of medical and laboratory examinations, you are infected with the agent (Human Immune-deficiency Virus) of a communicable disease, namely Acquired Immune Deficiency syndrome; and
- (b) You have continued to engage in sexual activity since becoming infected; and
- (c) Acquired Immune Deficiency Syndrome is spread to other persons by such sexual activity and needle sharing; and
- (d) Your behaviour presents and has presented a risk to the health of persons in the community; and
- (e) Counselling is required to provide you with information on the prevention of spread to others through sexual activity and needle sharing; and
- (f) This Order is necessary to decrease or eliminate that risk.

Therefore, I am ordering you:

- 1. Not to engage in sexual acts that involve any penile penetration into your mouth or anus, or into the mouth, anus or vagina of another person;
- 2. Not to provide to any other individual equipment or other material, such as needles or syringes, which you have used to inject drugs or other substances, or which you have used to penetrate your skin;

3. To provide to the Health Department within 2 working days of the receipt of this Order, the names and last known addresses of all of the persons with whom you have engaged in such sexual activity or needle sharing in the twelve months preceding the date on which this Order takes effect, and;
4. To attend for further counselling at the Sexually Transmitted Diseases Clinic at Ontario within two working days from the date this order takes effect.

Failure to comply with this Order is an offence to which you may be liable on conviction to a fine of not more than \$5,000.00 for every day or part of each day on which the offence occurs or continues.

You are advised that you have a right to a hearing before the Health Protection Appeal Board in accordance with Section 43 of the *Health Protection and Promotion Act* if you mail or deliver to the undersigned [sic], and to the Health Protection Appeal Board, at Room 2 W 1175 Hepburn Block, Queen's Park, Toronto, Ontario, M7A 1R3, within fifteen days after this Order is served on you, notice in writing requiring a hearing.

This order takes effect when it is served on you.

Dated at _____ this _____ day of _____, 1989.

Medical Officer of Health,
Department of Health.