HIV Infection and the Law — A Medical Health Officer's Perspective

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The 1980s saw AIDS emerge as the number one media topic. Because two minority groups were particularly hard hit by the epidemic, gays and intravenous drug users (IVDUs), the question of human rights had to be dealt with by the health professionals. The issue of fighting the disease versus protecting human rights was often used as an excuse to ignore or break basic public health principles.

Many people hoped that the law could help to stop the spread of AIDS. Concepts such as Compulsory Testing and Quarantine were debated in the media. In the end, virtually all public health jurisdictions concluded that compulsory testing and quarantine were of no value, and opted for programs that allowed some form of anonymous testing. Legislators have tried for centuries to stop prostitution with a variety of laws. AIDS, like prostitution, cannot be controlled by laws. Therefore the legal system cannot do much to stop the spread of AIDS. However, ill-advised laws can drive AIDS patients underground and thus the legal system could assist the spread of the AIDS virus. Where a criminal law is broken, the criminal process should be used. But education, not the threat of legal action, is the tool of public health.

I. THE SPREAD OF HIV INFECTION

As the Medical Health Officer of Vancouver, I always begin any presentation with two themes: "AIDS is hard to get" and "AIDS is preventable". From the beginning of the epidemic, two major routes of transmission have been known: sexual contact and sharing of blood intravenously. Thus, AIDS is clearly preventable, because you do not have to share a needle with somebody else and you can elect not to have sex with somebody. Even if you choose to share a needle, you can clean it with bleach before use, and even if you choose to have sexual intercourse with someone you can insist that a condom be used, and thus greatly reduce the risk of transfer of infection.

The news media, of course, loved the sensational side of AIDS stories, and were always ready to provide a platform for calls for quarantine, jail and compulsory testing. The consensus of most public health personnel was that quarantine had not worked in most other epidemics and had no useful place in this one.

II. QUARANTINE

In late 1987, the Province of British Columbia amended its *Health Act*[1] to state that Where a medical health officer has reasonable grounds to believe that:

> 8. [...] (1) *(a) a person has a reportable communicable disease or is infected with an agent that is capable of causing a reportable disease [the latter part of the statement clearly being HIV infection], and;*
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> *(b) the person is likely to, wilfully, carelessly, or because of mental incompetence, expose others to the disease or the agent, he may order the person* [...]*;*
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> *(c) to place himself in isolation, modified isolation or quarantine [quarantine being defined as having the meaning prescribed by the Lieutenant Governor in Council]* [...].

Failure to do what is ordered by the Medical Health Officer would lead to the laying of a charge under the Act and the result could be that "the person be detained in a place prescribed by the Lieutenant-Governor in Council for detention [...] for a period not to exceed one year."[2]

The changes to the Act now portrayed the Medical Health Officer as having the power to deal with those wilfully spreading the disease. The problem was how to prove that a person is both wilfully and carelessly spreading the disease. Neither the Ombudsman nor the Attorney General's staff could suggest what evidence would be required. Both felt that convictions under the *Health Act* were highly unlikely. The "quarantine" could only be for up to one year, but a person with AIDS is infected for life. Finally, the only place designated by the Lieutenant-Governor is the Vancouver General Hospital.

In the summer of 1988, four individuals with tuberculosis were held at the Vancouver General Hospital for treatment. Two of these individuals were shackled, one for six months. The Act was then changed, and the impression given in the media was that we could now shackle all people with AIDS. Throughout this discussion, the Medical Officer repeatedly explained the difference between tuberculosis and AIDS. Tuberculosis can be casually spread; AIDS cannot.

After consultation with the Ombudsman and Attorney General's department, the Director of the AIDS Program and the Medical Health Officer concluded that the *Health Act* was not of much value in preventing or controlling this disease. From a public health standpoint, the damage a prosecution would do to our street programs and education programs

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1. *Health Act*, R.S.B.C. 1979, c. 161 as am. by *Health Statutes Amendment Act, 1987*, S.B.C. 1987, c. 55, s. 8(1) [hereinafter the *Act*].

2. *Supra* note 1, s. 8(a)(1.1)(e).

would be far more substantial than the small gain from a single prosecution. The likelihood of a conviction was also small.

The public must never be allowed to believe that Government can protect them from AIDS. Individuals are responsible for their own health. They can prevent themselves from contracting AIDS. Quarantine sounds good, but would only work if the person infected had a life sentence that really meant life.

III. COMPULSORY TESTING

Some individuals believed the law could assist in stopping the spread of AIDS through compulsory testing. However, once public health personnel pointed out the problems, almost everybody agreed that compulsory testing made no sense.

Every person to be tested would have to be tested now, two months from now, and six months from now. Then they would have to be re-tested three times every time they left the country. Moreover, fingerprints or genetic marking would have to be done to ensure the person was whom they claimed they were.

IV. REPORTING

There are basically two types of reporting practices in Canada. One type requires that all "cases" of AIDS be reported (British Columbia), the other that all HIV-infection be reported (Ontario).

The British Columbia method has worked well for that province because with most cases in B.C. ending up at one time or another in a Lower Mainland hospital, and particularly St. Paul's Hospital, we have been able to establish a good reporting system of "Clinical AIDS" cases. Also, by reviewing death notices and following up certain deaths (e.g., young males who die of pneumonia), we have maintained a high reporting level. Also, since virtually all AIDS tests are done by the Provincial Laboratory, the Provincial Epidemiologist has a very good knowledge of the test results including reason for test, age, sex, risk factors, etc.

The major value in reporting positive cases is in follow-up. If all positive tests were intensely followed up, contacts who may not know they were exposed could be tested. Moreover, with AZT proving to be effective, people could be found earlier and could benefit from treatment. For example, despite our records showing over 100 females with positive HIV tests, only four are on AZT. Before AZT and some of the newer drugs, there was not a lot to offer individuals who had been identified. The Public Health Service presumes that the physician or clinic ordering the test does the pre- and post-test counselling.

Some health jurisdictions do have follow-up of reported HIV-positive cases. However, an intense follow-up program requires a large number of staff. They would

undoubtedly find large numbers of reported cases with false names who would only marginally cooperate with contact tracing.

V. AIDS AND JUDICIAL INTERVENTION

It is interesting to note that in the cases reported below, none of the judges included the HIV status of the accused in their judgments.

A. Alberta Provincial Court — Gordon Arthur Summer[3]

Mr. Summer was alleged to have had unprotected sexual intercourse while knowing he was infected with the AIDS virus, thereby endangering the lives and health of the public, contrary to section 180 of the Criminal Code of Canada (common nuisance). Mr. Summer pleaded guilty to the charge and was sentenced by the judge to one year imprisonment, followed by three years' probation from the date of release. A five-count information and a two-count information were stayed. No comment was made in the sentencing about his sexual conduct for the future except to advise continued medical consultation.

B. British Columbia Provincial Court — Robert Marc Cormier

Mr. Cormier was charged with sexually assaulting a nine year old boy. He was sentenced by Judge McGivern to 10 years in jail plus a one year sentence and two nine month terms with the result that his total incarceration would be 11 years. No reference in the sentence was made to the fact that Mr. Cormier carried the AIDS virus.

C. Order of the Medical Health Officer, Capital Regional District (Victoria) — Renee Shari Lindquist (the name given in the newspaper)

An order was issued under the British Columbia *Health Act* to the person in question to present herself to a Victoria hospital for a short period for a complete medical, psychiatric, and addiction treatment assessment. The Medical Health Office was to review the assessment and issue any further orders.

She left Victoria without following the order. She was arrested in Alberta and charged with possession of stolen property. On July 14, 1990, she was sentenced to 90 days in jail for her part in a Credit Union robbery in Lethbridge. After she completed her jail term, she returned to the streets of Victoria (as reported by her father in the Victoria paper).

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3. *R.* c. *Summer*, [1989] A.W.L.D. 889 (Alta. Prov. Ct.).

D. Vancouver

The Medical Health Office in Vancouver is aware of 14 HIV-positive prostitutes in Vancouver. In addition, at least twice a week, somebody phones to complain of an HIV individual having unprotected intercourse. When questioned, the caller admits the intercourse was voluntary and the reason given for not wearing a condom is that alcohol and drugs clouded the decision. When the Medical Health Office staff ask callers if they will testify in court, they refuse, but they expect the Medical Health Officer to do something in any case.

SUMMARY

Quarantine is designed "to detain or isolate on account of suspected contagion". Isolation is defined as "the segregation of patients with communicable disease". Both of these concepts were based on there being a period when an individual is infective, but that after a period of time (with or without treatment) he or she would no longer be infective.

For HIV-positive persons, these concepts are meaningless. They are not infective to individuals unless they have intercourse or share their blood. There is no treatment to render them not infective, and they remain infective for life.

How will the courts deal with irresponsible members of society who test HIV-positive yet continue to have unprotected sex or share needles? Will the courts follow Pierre Elliot Trudeau's assertion that the government does not belong in the bedrooms of the nation? Will the courts leave consenting adults to be responsible for their own conduct? To date, the courts have dealt severely with criminal activities against youngsters, have dealt relatively lightly with criminal activities involving consenting adults, and have dealt lightly with a first time offender with an outstanding Medical Health Officer's order.

My position is that, where criminal laws are broken, the criminal process should be used, not the Public *Health Act.* Where consenting adults have intercourse or share needles, those individuals are responsible for their own health. They must not be allowed to believe that the law can protect them from their own actions.

AIDS is preventable. AIDS is hard to get. The Public Health Service's role is to supply support services, education, testing and counselling. We do not need to tie up the court system with public health cases brought on by consenting adults. The job of the Public Health Service is to educate, not prosecute.