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EDITOR'S NOTE

David Parry *

The MJLH continues to steam along with great success. We are pleased with the growing interest the legal and academic community has shown in our journal and the ever-increasing quality of the scholarship the MJLH attracts. Le résultat, avec un peu de chance, est un numéro particulièrement fort sur des questions très pertinentes en droit de la santé.

This issue opens with a two-article special section on the criminalization of non-disclosure of HIV status to sexual partners. Isabel Grant and Matthew Cornett offer opposing analyses just as the Supreme Court of Canada gets set to hear an appeal on the matter. We are also pleased to republish the first-ever observation of what would become known as AIDS in the medical literature.

Our third and final article is a deeply-researched yet vehement discussion of end-of-life care. Yude M Henteleff, Mary J Shariff and Darcy L MacPherson explore avenues for finding a human right to palliative care under the *Canadian Charter of Rights and Freedoms*. They discuss possible foundations under sections 7 and 15. This discussion is very timely, particularly in light of the National Assembly of Quebec's recent public consultations on "death with dignity".

I would also like to take this opportunity to invite you–our readers–to become part of the discussion around this issue's articles and the questions they raise. Visit our website (http://mjlh.mcgill.ca) where you can post responses to our articles and even submit blog entries on topics of current interest for publication on the MJLH Health Law Blog.

The MJLH's annual "McGill Student Colloquium on Health and Law" continues to be a strong journal tradition. This year's topic was reproductive justice, and we were honoured to have Jessica Yee, reproductive justice activist, as our keynote speaker. Very special thanks to our hard-working Colloquium Chairperson, Corri Longridge.

En terminant, je remercie également notre conseillère facultaire, Professeure Angela Campbell, qui a toujours su nous guider par ses excellentes suggestions. Je remercie notre équipe de rédacteurs pour leur dévouement, leur enthousiasme et leur travail acharné. The MJLH has only met such great success through their superb efforts.

À votre santé!

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* Editor-in-Chief, McGill Journal of Law and Health, Vol. 5.

HIV/AIDS INTRODUCTION

David Parry *

On June 5th 1981, the Centers for Disease Control in Atlanta published its *Morbidity and Mortality Weekly Report* (MMWR) as it does every Friday.[1] It contained a brief report (reproduced on page 103) of five gay men from Los Angeles, all around the age of thirty and previously in good health, treated for a rare type of pneumonia. What puzzled their physicians was that this pneumonia is almost exclusively limited to patients with severely-weakened immune systems. The report concluded with the words, "All the above observations suggest the possibility of a cellular-immune dysfunction related to a common exposure that predisposes individuals to opportunistic infections … " That dysfunction would become known as AIDS.

Thirty years on, HIV/AIDS still presents challenging societal questions. One of those questions is: should failure to disclose one's HIV-positive status to a sexual partner attract criminal liability? If so, under what circumstances? The MJLH is fortunate enough to be publishing the following two articles on this subject by Isabel Grant and Matthew Cornett. Each offers a different analysis, and arrives at opposing conclusions to the other.

The landmark case in non-disclosure of HIV status is the Supreme Court of Canada's 1998 decision *R v Cuerrier*,[2] which established that failure to disclosure ones HIV status can be prosecuted as aggravated assault. Central to the Court's reasoning was that non-disclosure constitutes fraud vitiating consent to the sexual act. The Court's analysis of fraud centered on whether the accused acted dishonestly in obtaining consent to the sexual act, and whether the exposure to HIV resulted in a significant risk of bodily harm. On this latter point, the Court found that this threshold of significant risk was met.

Now, thirteen years later, the Supreme Court of Canada will be re-visiting non-disclosure of HIV status with the upcoming *R v Mabior*[3] appeal. Central to the appeal is the "significant risk" part of the test established by *Cuerrier*. The accused in *Mabior* had an undetectable viral load at the time of the sexual acts in question. One of the issues for the Court is whether an undetectable vi-

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* Editor-in-Chief, McGill Journal of Law and Health, Vol. 5.

[1] Centres for Disease Control and Prevention, "Pneumocystis Pneumonia – Los Angeles" (1981) 30:21 Morbidity and Mortality Weekly Report 250.

[2] [1998] 2 SCR 371.

[3] *R v Mabior*, 2010 MBCA 93.

ral load on the part of the accused sufficiently reduces the risk towards the complainant to below the significance threshold required for a conviction of aggravated sexual assault.

In an appeal that could have major repercussions for Canadian criminal law, HIV/AIDS public health initiatives, and persons living with HIV as well as their partners, the MJLH would like to reflect on what has and has not changed in the HIV/AIDS epidemic that has brought us to *Mabior*.

Advances in treatment mean that HIV/AIDS is no longer the death sentence it was in 1992, when Henry Girard Cuerrier started his sexual relationship with KM. In 1995, Dr. David Ho championed the use of combining antiretroviral medications [4] in what became known as "highly active antiretroviral therapy" (HAART) or the "AIDS cocktail". The results were dramatic: by 1998, when *Cuerrier* reached the Supreme Court of Canada, HIV/AIDS mortality rates had fallen by nearly two-thirds.[5] Life expectancy has also improved dramatically, so that now a 20-year old diagnosed with HIV having access to HAART can expect to live another 50 years.[6]

HAART therapy has also made it possible to reduce HIV to undetectable levels in infected persons' blood. Viral load refers to the number of viruses in a specific quantity of bodily fluid. With HIV, viral load is said to be "undetectable" when there are no more than 40 copies of the virus in 1 mL of blood.[7] An undetectable viral load is a medically-useful indicator that therapy is working. However, the extent to which an undetectable viral load means that the risk of transmission is low to zero on an individual per-case basis is unclear.[8]

Stigma and discrimination towards HIV-positive persons, nevertheless, remains. Such attitudes date back to when HIV/AIDS was poorly understood. Tellingly, before AIDS, the syndrome was called GRID for "gay-related immune deficiency". In 1988, almost one-third of Americans supported marking

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[4] David Ho, "Time to Hit HIV, Early and Hard" (1995) 333:7 The New English Journal of Medicine 450.

[5] Frank J Palella et al., "Declining Morbidity And Mortality Among Patients With Advanced Human Immunodeficiency Virus Infection" (1998) 338 The New English Journal of Medicine 853.

[6] R Hogg, "Life Expectancy of Individuals on Combination Antiretroviral Therapy in High-Income Countries: A Collaborative Analysis of 14 Cohort Studies" (2008) 372 The Lancet 293.

[7] David P Wilson et al., "Relation Between HIV Viral Load and Infectiousness: A Model-Based Analysis". (2008) 372:9635 The Lancet 314.

[8] *Ibid*.

HIV-positive individuals with a tattoo.[9] And even by 1999, one in five Americans thought that HIV-positive people "do not care" if they infect other people.[10] Part of the destructive force of HIV/AIDS is its ability to play into people's prejudices, and we thus must question whether some of our laws and policy decisions are borne of such prejudices.

That HIV/AIDS still strikes the most vulnerable of our society has only become much more apparent. When first identified, HIV/AIDS struck marginalized groups in the Western world, such as gay men and intravenous drug users. Now, however, the overwhelming majority of HIV/AIDS cases affect the world's poorest people. Sub-Saharan Africa alone has 22.4 million of the 33.4 million people living with HIV worldwide[11]—that represents 67% percent of those infected.

The number of people infected and the rate of new infections of HIV have changed radically. Prevalence of a disease measures the percentage of a given population (for example, the province of Quebec or gay men in Montreal) with the disease in question at a given time, whereas incidence measures the rate at which new cases of the disease arise during any given time period (for example, number of new infections per year).

Both prevalence and incidence must be examined to get the full picture of the changing HIV/AIDS epidemic. The prevalence of HIV in Canada was estimated at 65,000 persons in 2008,[12] which is a substantial increase over 1996 when there were 41,000 persons infected.[13] This increase is partly credited to HAART therapy and the fact that people with HIV are living longer.

However, the increase in prevalence also means that there are more and more people living with HIV, increasing the potential for non-disclosure cases

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[9] Robert J Blendon & Karen DoneLan, "Discrimination Against People with AIDS" (1988) 319:15 The New England Journal of Medicine 1022.

[10] Gregory M Herek et al., "HIV-Related Stigma and Knowledge in the US" (2002) 92:3 American Journal of Public Health 371.

[11] UN AIDS, online: World Health Organization <www.unaids.org/en/media/unaids/contentassets/dataimport/pub/factsheet/2009/20091124_fs_global_en.pdf>.

[12] Public Health Agency of Canada, "National HIV Prevalence and Incidence Estimates in Canada for 2008" (2010) HIV/AIDS Epi Updates, online: PHAC <www.phac-aspc.gc.ca/aids-sida/publication/epi/2010/pdf/EN_Chapter1_Web.pdf>.

[13] Public Health Agency of Canada, "National HIV Prevalence and Incidence Estimates for 1999: No Evidence of a Decline in Overall Incidence" (2003) HIV/AIDS Epi Updates, online: PHAC <www.phac-aspc.gc.ca/publicat/epiu-aepi/hiv-vih/estima-eng.php>.

to arise. Moreover, there is also a worrying increase in the incidence of new HIV infections. In 2008, incidence was estimated from 2,300 to 4,300 new infections[14] up from 2,100 to 4,000 in 2002.[15] The largest increase in incidence is amongst heterosexuals; however, amongst men who have sex with men, incidence is also on the rise–up 34% in 13-29 year olds in the US.[16] The reasons for this increase in recent years are poorly understood.

Finally, for the first time ever, we now have the ability to stop the HIV/AIDS epidemic and eradicate the disease. A recent clinical trial–stopped early because of its success–found that starting antiretroviral therapy early resulted in a 96% reduction of transmission from the infected to the uninfected partner.[17] Conceivably, wide availability of HAART therapy combined with safer sex practices and public health initiatives could eliminate transmission. Absent transmission, HIV/AIDS would simply die out. As *The Economist* astutely opined, "The question for the world will no longer be whether it can wipe out the plague, but whether it is prepared to pay the price."[18]

Put together, what has changed and not changed in the HIV/AIDS epidemic carves a complicated path bringing us from the original MMWR article, to *Cuerrier*, and now to *Mabior*. To what extent should scientific advancement inform the criminal law in this area? Does a reduction in population transmission with HAART therapy have any bearing on the individual case brought before a court and the significant risk threshold? Should the fact that more and more people are living with HIV suggest maintaining a criminal response to deter would-be "offenders"? Is the deterrence power of criminal law really working as effective public policy in the face of increasing HIV incidence? Is the current Canadian approach under *Cuerrier* a product of the social attitudes towards HIV-positive persons at the time? Have those attitudes changed?

These are the issues that are discussed in the following pages in the articles by Grant and Cornett. They are also the issues with which the Supreme Court of Canada must grapple in the coming months. We invite you to submit comments on the articles that follow on our website (http://mjlh.mcgill.ca).

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[14] *Supra* note 12.

[15] HIV/AIDS Epi Updates, online: PHAC <www.phac-aspc.gc.ca/publicat/epiu-aepi/epi-06/pdf/epi06_e.pdf>.

[16] Joseph Prejean et al. "Estimated HIV Incidence in the United States, 2006–2009" (2011) 6:8 PLoS ONE.

[17] "Initiation of Antiretroviral Treatment Protects Uninfected Sexual Partners from HIV Infection" *HIV Prevention Trials Network* (12 May 2011).

[18] "The End of AIDS" (2 June 2011) *The Economist*.

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THE PROSECUTION OF NON-DISCLOSURE OF HIV IN CANADA: TIME TO RETHINK *CUERRIER*

Isabel Grant *

The author of this article argues that Canada's current approach to the criminalization of HIV transmission is deeply flawed and cries out for clarification. The article first considers the risk of transmission of HIV under various conditions, as determined by recent scientific studies, and concludes that HIV is not easily transmissible through sexual activity. It next examines several crucial factors that contribute to the significance, or lack of significance, of sexual activity by HIV-positive individuals, concluding that the current law creates a "numbers game" for triers of fact. The article then proceeds to a comparative analysis of other Commonwealth countries, demonstrating that Canada is unique in the scale of its prosecution of HIV transmission, as well its reliance on assault, sexual assault, and murder-related charges. The article concludes by examining several specific problems with the *Cuerrier* test, and proposes future directions which the Supreme Court could consider.

L'auteure de cet article suggère que l'approche canadienne courante de criminalisation de la transmission du VIH est défaillante et demande d'être. L'article considère d'abord le risque de transmission du VIH sous plusieurs conditions telles que déterminées par des études scientifiques récentes pour conclure que le VIH ne se transmet pas facilement par l'activité sexuelle. Ensuite, l'auteure examine plusieurs facteurs cruciaux qui déterminent l'importance ou l'insignifiance de l'activité sexuelle d'un individu séropositif. Elle en conclut que le droit courant crée un jeu de nombre pour les juges de faits. L'article procède ensuite à une analyse comparative avec d'autres pays du Commonwealth pour démontrer que le Canada en ce qui a trait au nombre de ses poursuites relatives à la transmission du VIH, ainsi que pour sa tendance à fonder de telles actions sur des accusations de voies de fait, d'agression sexuelle et de meurtre. L'article se termine en examinant plusieurs problèmes propres au test de *Cuerrier* et propose certaines directions que la Cour suprême pourrait considérer ultérieurement.

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Introduction

Canada has witnessed one of the highest levels of prosecution for the non-disclosure of HIV status to one's sexual partners of any developed country in the world. We also have the dubious distinction of being the only country to witness first-degree murder convictions in a non-disclosure case where two of the complainants died of AIDS.[1] This paper examines the role of the courts in this process, tracing some of the current problems back to the Supreme Court of Canada's decision in *R v Cuerrier*.[2] Specifically, this paper considers how *Cuerrier* has been interpreted in subsequent cases in light of the scientific developments in the field of HIV/AIDS and suggests an alternative, more restrained approach to prosecuting these offences.

The Supreme Court of Canada in *Cuerrier* held that not disclosing one's HIV-positive status to a sexual partner could constitute fraud which would vitiate consent to sexual activity, provided there was a *significant risk of serious bodily harm* to the complainant.[3] At the time of *Cuerrier*, when highly active antiretroviral treatments (HAART) for HIV were in their infancy, HIV almost inevitably led to AIDS and premature death; therefore, the risk of transmission of HIV was always going to be considered a significant risk of serious harm. Further, because the Court held that this risk "endangered life" even where the virus was not transmitted, a finding of aggravated assault was made out. The way in which the Court used sexual assault to build the elements of aggravated assault in *Cuerrier* opened the door to charges of either aggravated assault or aggravated sexual assault in the vast majority of subsequent cases. Not every jurisdiction takes such an expansive approach to criminalization. As will be discussed below, England and Wales, for example, only criminalizes intentional or reckless transmission of the virus.

More than 10 years after *Cuerrier*, certain dilemmas in prosecuting non-disclosure of one's HIV-positive status cry out for clarification by Canada's highest court. Can juries continue to make decisions about the level of risk on a case-by-case basis without further elaboration by appellate courts as to the significant risk standard? Triers of fact are given no standards to follow, just numbers and probabilities from which they must determine the significance of

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[1] See discussion in *R v Aziga*, 2010 ONSC 3683, [2010] OJ No 2763 (QL) (Johnson Aziga was convicted by a jury of "two counts of first degree murder, ten counts of aggravated sexual assault, and one count of attempted aggravated sexual assault" at para 2).

[2] *R v Cuerrier*, [1998] 2 SCR 371, 127 CCC (3d) 1 [*Cuerrier* cited to SCR].

[3] This formulation will be referred to as the "*Cuerrier* test" in this paper.

the risk. Leaving this assessment in the hands of juries inevitably creates uncertainty about how thresholds of risk are applied, resulting in inconsistent outcomes and a lack of clarity in the law.[4] What are the justifications for criminalizing non-disclosure where the virus is not actually transmitted? Should we be using two of our most serious offences against the person in cases where no bodily harm is caused? If the virus is not transmitted, how much risk is significant enough to justify serious criminal liability? If, for example, the risk of transmission is 1 in 10,000, can we really say that life is endangered?

The *Cuerrier* Court could not have foreseen all the possible factors that play into determining whether a risk of serious bodily harm is significant. Nor did it foresee the extent to which *any* threat of transmitting HIV would come to be seen as significant in future cases. In this paper, I will argue that the way courts have interpreted *Cuerrier* has left us with too broad and too uncertain a test for criminalization of non-disclosure. It will be argued that it is time for a new approach to non-disclosure prosecutions, an approach that takes into account the rapid scientific developments that have changed our understanding of, and ability to treat, HIV, and that distinguishes between cases in which the virus is transmitted and those in which it is not. It will be argued that the record of HIV prosecutions in Canada is a disturbing one, and that it is essential that we find a way to prosecute only the most flagrant and serious cases that involve an ongoing pattern of non-disclosure. Two recent appellate decisions have signalled a more cautious approach to criminalization, although both explicitly urged reconsideration by the Supreme Court of Canada.[5]

Part I of this paper sets out a brief summary of the literature on rates of sexual transmission of HIV to demonstrate both that HIV is not easily transmissible through sex and that we have the means to reduce these rates even further. Part II then examines recent developments in the case law to demonstrate how lower courts have interpreted the significant risk of serious bodily harm test. I examine each of the factors with which judges and juries have been confronted in assessing the degree of risk in a particular case and discuss the difficulties inherent in applying a legal standard to statistical probabilities. Part III provides a brief review of three other Commonwealth jurisdictions,

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[4] Even within a province there can be inconsistency: *R v Wright*, 2009 BCCA 514, 287 BCAC 1, 256 CCC (3d) 254 [*Wright*]; *R v JAT*, 2010 BCSC 766 [*JAT*]. There is also inconsistency between provinces, compare *Wright*; *R v DC*, 2010 QCCA 2289 [*DC* (CA)].

[5] *R v Mabior*, 2010 MBCA 93, 258 ManR (2d) 166, [2011] 2 WWR 211, leave to appeal to SCC granted, 33976 (5 May 2011) [*Mabior* (CA)]; *DC* (CA), *ibid*, leave to appeal to the Supreme Court of Canada has been granted, 34094 (26 August 2011).

demonstrating that the expansive Canadian approach is not the only option for dealing with non-disclosure. From this analysis, I move on to argue in Part IV that the significant risk of serious bodily harm test has not served us well in Canada, in part because lower courts have ignored the caution expressed by the Supreme Court of Canada in *Cuerrier*, and in part because the test fails to distinguish between levels of culpability and levels of harm. The result has been the over-criminalization of persons with HIV who have not disclosed their HIV-positive status to their sexual partners, a development that contributes to the demonization of persons with HIV. I have elsewhere reviewed the arguments for and against criminalization.[6] In this paper, I accept that some level of criminalization is virtually inevitable in Canada. However, it is not too late to re-assess Canada's aggressive approach and to rethink the *Cuerrier* test.[7] Part V argues that aggravated assault and aggravated sexual assault should be reserved for the most serious cases, in which transmission of the virus takes place and there is a pattern of non-disclosure demonstrating a reckless disregard for the consequences to others. Where prosecution is necessary in cases involving no transmission of the virus, less serious offences—such as common nuisance or (sexual) assault—are more appropriate than a serious consequence crime. Prosecutions should not be undertaken where a condom was used consistently, or where there is clear evidence of an undetectable viral load.

While *Cuerrier* applies to any sexually transmitted infection, there are only a handful of Canadian cases involving charges outside the context of HIV.[8]

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[6] Isabel Grant, "The Boundaries of the Criminal Law: The Criminalization of the Non-disclosure of HIV" (2008) 31 Dal LJ 123 at 172 [Grant, "The Boundaries of the Criminal Law"].

[7] Indeed, leave to appeal has been granted in two recent cases: *Mabior* (CA), *supra* note 5 and *DC* (CA), *supra* note 4.

[8] See *R v Jones*, (2002) NBQB 340, [2002] NBJ No 375 (QL) [*Jones*] (where the accused was acquitted because the risk of transmission of hepatitis C was too low); "Man with Hepatitis B Jailed for Sexual Assault" *CBC News* (3 March 2010) online: CBC News <www.cbc.ca/news/canada/prince-edward-island/story/2010/03/03/pei-hepatitis-women-sexual-assault.html>; Megan Gillis, "Soldier Banned from Sex Unless He Warns of Herpes" *Ottawa Sun* (18 February 2010) online: Ottawa Sun <www.ottawasun.com/news/ottawa/2010/02/18/12937306.html> (accused charged with six counts of aggravated sexual assault and six counts of criminal negligence causing bodily harm); "Redoubling Global Efforts to Support HIV/AIDS and Human Rights" (2010) online: HIV/AIDS Policy and Law Review <www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1775> (an Ontario case where a man was

The criminalization of nondisclosure is really about HIV/AIDS, a condition that has been stigmatized, and its victims marginalized, since its emergence in North America just decades ago. Throughout the legal analysis, we must ask ourselves why our criminal justice system has taken such an extraordinarily harsh approach in this context, but not with illnesses that are much more easily transmitted.

I. The Risk of Sexual Transmission of HIV

Before examining the factors that contribute to significant risk, it is useful to establish the general risk of sexual transmission of HIV. Contrary to public opinion, HIV is not generally an easily transmissible virus through sexual activity. The following estimates on the risk of sexual transmission are approximate and do not take into account factors that alter the risk in individual cases. Furthermore, the results from different studies vary considerably, so they should not be taken as being definitive. Estimated risk and the methodology used to measure it are topics of ongoing debate within the field.[9]

In a systematic review and meta-analysis, one study found that for unprotected anal intercourse, where the insertive partner is HIV-positive, there is an average 1 in 71 per-act probability that the receptive partner will contract HIV.[10] Few studies have considered the per-act risk of transmission for unprotected anal intercourse where the receptive partner is HIV-positive. One study found the per-act risk to be as low as 1 in 1,666,[11] but that study was excluded from the meta-analysis due to methodological concerns.[12] For vaginal intercourse, the average risk in high-income countries has been identified by a meta-analysis as 1 in 1,250 per act that a man will transmit the virus to his female

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convicted of assault and sentenced to 12 months in prison for not disclosing that he carried the herpes virus).

[9] Marie-Claude Boily et al, "Heterosexual Risk of HIV-1 Infection per Sexual Act: Systematic Review and Meta-analysis of Observational Studies" (2009) 9:2 The Lancet Infectious Diseases 118 at 126-127.

[10] Rebecca F Baggaley, Richard G White & Marie-Claude Boily, "HIV Transmission Risk Through Anal Intercourse: Systematic Review, Meta-Analysis and Implications for HIV Prevention" (2010) 39 International Journal of Epidemiology 1048 at 1048, 1051.

[11] Eric Vittinghoff et al, "Per-Contact Risk of Human Immunodeficiency Virus Transmission Between Male Sexual Partners" (1999) 150:3 American Journal of Epidemiology 306.

[12] Baggaley, White & Boily, *supra* note 10 at 1050.

partner, and 1 in 2,500 that a female partner will transmit the virus to her male partner.[13]

It has been estimated that the use of condoms in sexual activity further reduces the above risks by an average of 80%.[14] Since this figure includes improper and inconsistent use, studies examining the risk associated with protected intercourse have found that the risk is even lower. According to the expert in *R v JAT*, the risk during anal intercourse where the insertive partner is HIV-positive drops to 1 in 1,666 when a condom is used.[15] Other studies have found that with condom use, the risk of transmission in vaginal sex decreases to 1 in 10,000 for the woman[16] and 1 in 20,000 for the man.[17]

Furthermore, there is consensus among experts that the lower the viral load, the lower the risk of transmission. An undetectable viral load (identified as below 40 copies per millilitre of blood by many HIV/AIDS treatment guidelines) has been estimated to reduce the risk of transmission to, at most, 1 in 8,620 for male-to-female vaginal transmission.[18] Where a viral load is suppressed as a result of HAART, the risk of transmission has been found to be reduced by 92%.[19] The risk that accompanies an undetectable viral load is so low that, in 2008, leading experts in Switzerland stated that the virus is essentially impossible to transmit (absent other risk factors).[20] The combined effect

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[13] Boily, *supra* note 9 at 118.

[14] Susan C Weller & Karen Davis-Beaty, "Condom Effectiveness in Reducing Heterosexual HIV Transmission" (2002) 1 Cochrane Database of Systematic Reviews at 2.

[15] *JAT*, *supra* note 4 at para 29.

[16] Steven D Pinkerton & Paul R Abramson, "Effectiveness of Condoms in Preventing HIV Transmission" (1997) 44:9 Social Science & Medicine 1303 at 1310.

[17] Carol L Galletlyn & Steven D Pinkerton, "Toward Rational Criminal HIV Exposure Laws" (2004) 32:2 Journal of Law, Medicine & Ethics 327 at 328.

[18] David P Wilson et al, "Relation Between HIV Viral Load and Infectiousness: A Model-based Analysis" (2008) 372:9635 The Lancet 314 at 315, table 1 (this represents a worst-case estimate, and there is a 95% chance that the true likelihood of transmission is even less likely than 1 in 8,620).

[19] Deborah Donnell et al, "Heterosexual HIV-1 Transmission After Initiation of Antiretroviral Therapy: a Prospective Cohort Analysis" (2010) 375:9731 The Lancet 2092.

[20] Pietro Vernazza et al, "Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitement antirétroviral efficace ne transmettent pas le VIH par voie sexuelle" (2008) 89:5 Bulletin des médecins Suisses 165 online: Aide Suisse contre le SIDA <www.aids.ch/f/hivpositiv/pdf/SAZ_f.pdf> (this finding was

of the above-cited research is that if the HIV-positive person has an undetectable viral load and a condom is used, the risk of transmission is infinitesimally low.

The risk of sexual transmission is also affected by a number of other variables including whether the infected partner has other sexually transmitted diseases and whether a man, engaged as the insertive sexual partner, is circumcised. [21]

II. The Nature of Significant Risk

Since *Cuerrier*, courts have been faced with the need to assess the nature of the risk of HIV transmission in the particular activity in question. Factors not contemplated in *Cuerrier*, such as viral load and the type of sexual activity, have come to play a significant part in such prosecutions. Yet different expert witnesses rely on different numbers, as our knowledge of sexual transmission risks is far from precise. The following section examines some of the factors that judges and juries consider in their calculations of whether the accused created a significant risk of serious bodily harm to the complainant.

A. Condoms

The one factor that decreases the risk of harm that was anticipated in *Cuerrier* was condom use. Justice Cory, writing for the majority, made a fairly strong statement–albeit in *obiter*–suggesting that careful condom use might negate fraud:

> To have intercourse with a person who is HIV-positive will always present risks. Absolutely safe sex may be impossible. *Yet the careful use of condoms might be found to so reduce the risk*

based on monogamous relationships, adherence to HAART, and the absence of other sexually transmitted infections; this statement caused significant controversy, largely due to the fear that it would encourage risk-taking behaviour). Testimony based on this statement caused a Geneva court to find that an accused man posed no risk: Cour de la justice (chambre pénal), Geneva, 23 February 2009, [2009] ACJP 60 (an English translation of the judgment is available online: AIDSLEX <www.aidslex.org/site_documents/CR-0066E.pdf>).

[21] Robert C Bailey et al, "Male Circumcision for HIV Prevention in Young Men in Kisumu, Kenya: A Randomised Controlled Trial" (2007) 369:9562 The Lancet 643; Helen A Weiss et al, "Male Circumcision and Risk of HIV Infection in Sub-Saharan Africa: A Systematic Review and Meta-Analysis" (2000) 14:15 AIDS 2361.

> *of harm that it could no longer be considered significant* so that there might not be either deprivation or a risk of deprivation.[22]

Justice McLachlin (as she then was) explicitly stated in her concurring minority judgment that her test for fraud negating consent to sex would not apply to protected sex because there must be a high risk or probability of transmitting the disease to warrant criminalization.[23] The Court in *Cuerrier* was conscious of the dangers of over-criminalization and stressed the gravity of the consequences of a conviction and the importance of not trivializing the offence.[24]

Some courts have interpreted *Cuerrier* to mean that only unprotected sex is criminalized. In *R v Agnatuk-Mercier*, both counsel agreed that the Crown had to prove that the alleged intercourse was unprotected.[25] In *R v Edwards*, the trial judge made an even stronger statement in favour of only criminalizing unprotected sex:

> It is not for a trial judge to expand what constitutes a criminal act. Such a determination is for the Legislature or the Supreme Court of Canada in its interpretation of Legislation. The gay community and its leaders vigorously urge the practice of safe sex, not abstinence. If the failure to disclose a contagious disease before engaging in 'protected' sex is to be a criminal offence, it is for the Legislature to so define such activity.[26]

In the highly-publicized case of football player Trevis Smith, the trial judge took the same approach: "I have to go on and satisfy myself beyond a reasonable doubt that if he did have sex that that sex was unprotected sex."[27] In *R c DC*, the trial judge determined that the crucial question for the vitiation of consent was whether the intercourse was protected or unprotected.[28]

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[22] *Supra* note 2 at para 129 [emphasis added].

[23] In fact, transmission is never "probable" in the sense of more likely than not from a few acts of unprotected intercourse. Professor Ferguson interprets *Cuerrier* as holding that disclosure is not required in the context of protected sex: Gerry Ferguson, "Failure to Disclose HIV-Positive Status and Other Unresolved Issues in *Williams*" (2004) 20:1 CR (6th) 42 at 48.

[24] *Supra* note 2 at paras 132, 137.

[25] [2001] OJ No 4729 (QL).

[26] 2001 NSSC 80 at para 25, 194 NSR (2d) 107, 50 WBC (2d) 255 [*Edwards*].

[27] *R v Smith*, [2007] SJ No 116 (QL) (SKQB) at para 59, aff'd on other grounds 2008 SKCA 61, 310 Sask R 230 [*Smith*].

[28] 2008 QCCQ 629, JE 2008-515 [*DC* (CQ)].

Some courts have gone out of their way to narrow the scope of Justice Cory's statement in *Cuerrier*. In an appeal from a committal to stand trial, *R v JT*, the British Columbia Court of Appeal stated that *Cuerrier* had not established that only unprotected sex gives rise to the duty to disclose.[29] Focusing on Justice Cory's use of the word "might" in the paragraph quoted above, Justice Donald stated, "I think the language acknowledges that it is a question of evidence whether in any given prosecution the risk is significant," implying that conviction could be possible even if a condom was used.[30] In *R v Wright*, the British Columbia Court of Appeal cited *JT* in finding that it is a question of fact whether condom use reduces risk below the significant level required to vitiate consent.[31] In a puzzling variation, an Ontario court acquitted an accused of aggravated sexual assault when the Crown was unable to prove that the intercourse was unprotected, but the accused was instead convicted of the included offence of sexual assault.[32] The judge held that the lack of disclosure vitiated consent, without ever considering whether there was a significant risk of serious bodily harm, as required by the *Cuerrier* test.[33]

Other courts have simply ignored the question of condom use. In *R v Mekonnen*,[34] the Court disregarded the fact that the three acts of vaginal intercourse between the accused and the complainant all involved the use of a condom. The accused and the complainant met in a hotel on three occasions and engaged in three acts of *protected* intercourse and one instance of fellatio that may or may not have been protected. The judge gave no weight to the fact that a condom was used during the three acts of vaginal intercourse. According to the judge, counsel agreed "that if I find that Mr. Mekonnen had sexual relations with [the complainant] without telling her that he was HIV positive then the case is made out."[35] The accused was convicted of aggravated sexual assault for three acts of protected intercourse where the virus was not transmitted. In *R c Parenteau*, although there was conflicting evidence about condom

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[29] 2008 BCCA 463, 288 BCAC 1, 256 CCC (3d) 246 [*JT*].

[30] *Ibid* at para 19.

[31] *Wright*, *supra* note 4 at para 39.

[32] *R v Felix*, 2010 ONCJ 322, [2010] OJ No 3371 (QL).

[33] *Ibid* at paras 71-72.

[34] 2009 ONCJ 643, [2009] OJ No 5766 (QL) [*Mekonnen*].

[35] *Ibid* at para 40.

use, the judge stated that the sole issue was whether or not the accused had disclosed his status before the first occasion of intercourse.[36]

The trial and appeal decisions in *R v Mabior*,[37] a complicated case involving multiple complainants, several of whom were teenagers, highlight the different approaches taken by courts regarding the question of condom use. The trial judge held that condom use alone was insufficient to reduce the risk to a level that was not significant. *Mabior* was complicated by the fact that the accused did not appear to use condoms consistently (he had a sexually transmitted infection) or carefully (there was evidence of condoms falling off and sex while both partners were highly intoxicated). Relying on expert evidence that condoms are only 80% reliable and only reduce HIV transmission by 80%, the trial judge found that consent is still vitiated if a condom is used by an HIV-positive person whose viral load is detectable: only the combination of an undetectable viral load and the use of a condom preclude liability. I have suggested elsewhere that this may have resulted from the trial judge's misapprehension about the 80% figure.[38] While condoms may be only 80% reliable, it does not follow that there is a 20% risk of transmission when a condom is used. As was discussed above, the risk of transmission is extremely low for protected sex and almost non-existent when a condom is combined with an undetectable viral load. It is noteworthy that none of the complainants in *Mabior* has tested positive for HIV.

The Manitoba Court of Appeal took a more restrained approach, recognizing that "criminal sanctions should be reserved for those deliberate, irresponsible, or reckless individuals who do not respond to public health directives and who are truly blameworthy."[39] The Court of Appeal held that the trial judge was wrong to hold that any risk of harm is significant and erred in failing to identify the baseline risk before assessing an 80% reduction of that risk. The risk of transmission the trial judge should have considered was not 20%, but 20% of "an already small baseline figure."[40] Thus, the risk of protected sex

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[36] 2010 ONSC 1500 at para 6, [2010] OJ No 1795 (QL) (the accused was ultimately acquitted because the trial judge found neither the accused nor the complainant to be a credible witness).

[37] 2008 MBQB 201, 230 ManR (2d) 184, 78 WCB (2d) 380 [*Mabior* (QB)].

[38] Isabel Grant, "Rethinking Risk: The Relevance of Condoms and Viral Load in HIV Nondisclosure Prosecutions" (2009) 54:2 McGill LJ 389 at 398 [Grant, "Rethinking Risk"].

[39] *Mabior* (CA), *supra* note 5 at para 55.

[40] *Ibid* at para 88.

was between 1 in 2,000 and 1 in 10,000.[41] The Manitoba Court of Appeal found that "consistent and careful use of condoms"[42] or "reasonably proper condom use"[43] reduces the risk below significance. The Court of Appeal set out 10 criteria for assessing the "careful use of condoms," recognizing that all 10 criteria constitute an "ideal" and are unlikely to be met in any given case.[44] Furthermore, the Court of Appeal clarified that if a condom breaks during sexual activity, the accused must disclose his or her status immediately so that the HIV-negative partner can take prophylactic measures to decrease the likelihood of becoming HIV-positive.[45] Applying this test to the facts, the Court of Appeal considered the nature of the condom use with each complainant (finding "a fair amount of recklessness" on the part of the accused)[46] to determine its impact on the significance of the risk for each charge. In developing this "careful use of condoms test," the Court of Appeal attempted to give substance to Justice Cory's *obiter* comment that condom use might reduce the risk of harm below significance. The Manitoba Court of Appeal began the process of determining the standard that must be met for condom use to reduce the risk below the significant level. The Court of Appeal recognized, however, that it will be difficult for the Crown to prove that condom use on a particular occasion was not careful enough:

> It is the Crown's obligation to prove its case beyond a reasonable doubt. To achieve the goal of careful and consistent condom use, as described by Dr. Smith, involves a complex series of steps. The inquiry as to whether there was careful and consistent use of a condom in a particular instance of sexual activity is likely to be an unrealistic endeavour given that the sexual acts at issue will often have occurred some time ago, in conjunction with the use of drugs and/or alcohol, and the participants may be young and unaware of how to properly use a condom. As an example, where disclosure of the accused HIV-positive status occurs sometime after the sex act, the actual condom is unlikely to

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[41] *Ibid* at para 89.

[42] *Ibid* at para 87.

[43] *Ibid* at para 92.

[44] *Ibid* at para 91.

[45] It should be noted that this did not prevent criminal liability in a 2009 Ontario case. The accused disclosed her status immediately after the condom ripped on the second occasion of protected intercourse. She pled guilty to two counts of sexual assault. See "Toronto Woman gets House Arrest for Failing to Disclose HIV Status to Man" *Canadian Press* (20 November 2009).

[46] *Mabior* (CA), *supra* note 5 at para 96.

> be available for examination and testing, so how is the Crown to prove that it did not meet the standards prescribed by Dr. Smith, particularly where it was the accused who provided and applied the condom?[47]

No court in Canada has yet been faced with a case in which a condom was used but the virus was nonetheless transmitted. In such a rare case, it would be necessary for the trier of fact to examine the nature of condom use on the facts to determine if it was reasonably careful. In cases in which a condom was used and no transmission took place, it is likely that courts will assume that condom use was reasonable, in the absence of evidence suggesting otherwise.

Other jurisdictions have taken a clearer position on condom use. In California, for example, the HIV-specific offence explicitly only criminalizes unprotected sex.[48] In the New Zealand case *Police v Dalley*, the accused was charged with criminal nuisance for having protected sex without disclosure. [49] The District Court of Wellington held that the use of a condom constituted "reasonable precautions and care" and thus the accused was acquitted.[50] The reasoning in that case reflects the New Zealand public health strategy focus on condom use rather than disclosure.

I have argued elsewhere that non-disclosure prosecutions should not be pursued in the context of protected sex,[51] in part because of the importance of the public health message that encourages condom use for everyone, and not just by the HIV-positive person. Focusing on condom use is a more effective public health response than relying on disclosure, as disclosure itself offers no protection. The assumption behind disclosure is that if the accused discloses his or her status, the parties will not engage in unprotected sex.[52] In this scenario, disclosure is a proxy for safer sex or abstinence. However, a large number

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[47] *Ibid* at para 151.

[48] *California Health and Safety Code* § 120291.

[49] *Police v Dalley*, [2005] NZAR 682 (DC) [*Dalley*].

[50] *Ibid* at para 39.

[51] Grant, "Rethinking Risk", *supra* note 38 at 400; Grant, "The Boundaries of the Criminal Law", *supra* note 6.

[52] Catherine Dodds et al, "A Telling Dilemma: HIV Disclosure Between Male (Homo)sexual Partners" (London: London School of Hygiene and Tropical Medicine, 2004) online: Sigma Research <www.sigmaresearch.org.uk/files/report2004e.pdf> (the authors conclude that it is not clear how disclosure impacts on subsequent sexual behaviour when dealing with men having sex with men).

of transmissions take place before the HIV-positive partner knows that he or she is infected, and one's level of infectivity is high during the initial period after infection.[53] Thus, reliance on disclosure is not an effective means of curbing transmission. Such reliance assumes that the HIV-positive partner has accurate information about his or her HIV status, which is often not the case.[54] Placing a burden on everyone, and not just the HIV-positive person, to reduce the risk of transmission (through, for example, insisting on condom use), will more effectively decrease the risk of transmission of HIV.[55] The legal system should encourage this public health message rather than undermine it.

B. Viral Load

Since the trial decision in *Mabior*, the courts have increasingly considered viral load in assessing the degree of risk presented by an accused. I have argued elsewhere that viral load should not be taken into account until our understanding of how it affects rates of transmission has developed.[56] However, it is clear that courts must now confront this issue, both because the degree of risk is being assessed on a per-case basis, and because we are seeing an increasing number of cases where the accused's viral load was undetectable. Our understanding of viral load has evolved; if courts do not consider viral load, they will develop a distorted perception of the risk posed by HIV-positive individuals. Nevertheless, a focus on viral load is not unproblematic because of

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[53] Bluma G Brenner et al, "High Rates of Forward Transmission Events After Acute/Early HIV-1 Infection" (2007) 195:7 Journal of Infectious Diseases 951; Gary Marks, Nicole Crepaz & Robert S Janssen, "Estimating Sexual Transmission of HIV from Persons Aware and Unaware That They are Infected with the Virus in the USA" (2006) 20:10 AIDS 1447.

[54] See Donald C Ainslie, "AIDS and Sex: Is Warning a Moral Obligation?" (2002) 10:1 Health Care Analysis 49. In Canada it is estimated that 26% of people living with HIV do not know their status; this number is estimated as high as 35% for heterosexual persons with HIV (Public Health Agency of Canada, "Summary: Estimates of HIV Prevalence and Incidence in Canada, 2008" (Ottawa: PHAC, 2009) online: PHAC <www.phac-aspc.gc.ca/aids-sida/publication/survreport/estimat08-eng.php>).

[55] I recognize, of course, that not everyone is in a position to insist on condom use. For example, women in abusive relationships, sex trade workers, or people in relationships of unequal power may well be unable to safely insist on condom use.

[56] Grant, "Rethinking Risk" *supra* note 38.

disparate access to the necessary medical evidence.[57] Not every HIV-positive person has access to ongoing medical care or the ability to keep regular appointments. It is also important to note that not every HIV-positive person has access to, or is able to tolerate, antiretroviral treatment.

Effective combination antiretroviral treatment, available since the mid-1990s, has improved to such a degree that it is now possible to reduce the level of the virus in a person's blood to undetectable levels. This does not mean that the virus is not present, but rather that the levels are so low that current tests cannot detect it in the blood.[58] Our understanding of what this means for HIV transmission has also evolved since HAART first became available. As outlined above, scientists now believe that a low or undetectable viral load makes transmission of HIV from an infected person to his or her sexual partner extremely unlikely. We also now know that HIV is most transmissible when the viral load is high. Some studies have found that as many as half of new HIV transmissions take place in the acute stage of the infection when the viral load is as high as 1.26 million copies per millilitre of blood,[59] before the individual knows that he or she is HIV-positive.[60] HAART medications have also been found to increase life expectancy of those infected with HIV. One study estimated that a person can expect to live into their early 60s after diagnosis at the age of 20 if they begin taking combination therapy immediately.[61] Other research has rated HAART's effects higher still; under some conditions life expectancy was found to be almost normal.[62] Expert evidence in *Mabior* stated

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[57] See e.g. *Wright*, *supra* note 4 at para 33, in which there was no evidence regarding the accused's viral load at the time of the sexual activity. The court in *Wright* essentially put the burden on the accused to establish a low viral load.

[58] The virus may still be detectable in other bodily fluids, such as semen.

[59] Maria J Wawer et al, "Rates of HIV-1 Transmission per Coital Act, by Stage of HIV-1 Infection, in Rakai, Uganda" (2005) 191:9 Journal of Infectious Diseases 1403 at 1408.

[60] Marks, Crepaz & Janssen, *supra* note 53; Brenner et al, *supra* note 53 (Marks and his colleagues found that, adjusting for population size differences in the groups, the rate of transmission of HIV was 3.5 times higher in the group that was unaware of their HIV status then in the group that knew they had HIV).

[61] Antiretroviral Therapy Cohort Collaboration, "Life Expectancy of Individuals on Combination Antiretroviral Therapy in High-Income Countries: A Collaborative Analysis of 14 Cohort Studies" (2008) 372:9635 The Lancet 293 at 297.

[62] Charlotte Lewden et al, "HIV-Infected Adults With a CD4 Cell Count Greater Than 500 Cells/mm^3 on Long-Term Combination Antiretroviral Therapy Reach Same Mortality Rates as the General Population" (2007) 46:1 Journal of Acquired Immune Deficiency Syndrome 72.

that "many if not most persons infected with HIV who receive and are compliant with optimal care will die of a non-AIDS cause."[63] These numbers are just estimates, however, as the medications have not been available long enough to evaluate their long-term impact with certainty.

The first case to deal with viral load was *R v McKenzie*.[64] The judge dismissed viral load as a "fragile defense," pointing out that "[a]ll it reveals is the state of the blood tested on the day in question, not two weeks earlier, not two weeks later … To rely on slips of paper from a lab seems fraught with hazard."[65] The trial judge in *Mabior* expressed the same concern and required condom use *combined* with an undetectable viral load to reduce the risk below significant levels.[66]

In *Wright*, the accused appealed his conviction on two counts of aggravated sexual assault.[67] One of his arguments was that there was no evidence that he had a significant viral load at the time of the offence, and thus that there was insufficient evidence that he presented a significant risk of serious harm. The British Columbia Court of Appeal rejected this argument, holding that the jury was entitled to rely on the average rate of risk presented by the expert testimony, despite some evidence that the accused was taking antiretroviral medications at the time. The Court of Appeal did acknowledge the relevance of viral load, stating "this does not mean viral loads are irrelevant to the determination of criminal liability. If the viral load of the accused at the time of the sexual relations is known or can be estimated, then it will be very relevant to determining whether there was a significant risk of serious bodily harm."[68]

The Court of Appeal further held that it was up to the accused to introduce evidence about his own viral load. Denying that it was imposing a burden of proof on the accused, the Court stated that it is "a tactical decision for the accused to make on the basis of his assessment of the Crown's case."[69] Thus, the Crown need not lead evidence of viral load in each case to prove that the risk

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[63] *Mabior* (CA), *supra* note 5 at para 63.

[64] *R v McKenzie*, (9 March 2006), Windsor (Ont Sup Ct Just), Donohue J cited in Isabel Grant, "Rethinking Risk: The Relevance of Condoms and Viral Load in HIV Nondisclosure Prosecutions", Case Comment, (2009) 54:2 McGill LJ 389 at 402.

[65] *Ibid*.

[66] *Mabior* (QB), *supra* note 37.

[67] *Wright*, *supra* note 4.

[68] *Ibid* at para 32.

[69] *Ibid* at para 33. Note that the Manitoba Court of Appeal expressly agrees with this passage: *Mabior* (CA), *supra* note 5 at para 105.

is significant, but an accused may meet expert evidence about risks of transmission with specific information about his or her own viral load, which will make the risk assessment more precise and individualized to the accused. The result is that an undetectable viral load will constitute a defence if established by the accused, but the starting point, in the absence of evidence, is that the accused has a detectable viral load. There is no discussion in *Wright* of the standard of proof that must be met by the accused in this regard, or whether it is just a practical evidentiary burden. The judgment is probably a reaction to the heavy burden the Crown would face if required to prove a detectable viral load at the time of the alleged non-disclosure, thus rendering prosecution difficult where no evidence on viral load is available. Yet, if the risk of transmission in many cases is minimal, given the increasing number of HIV-positive individuals on HAART,[70] perhaps we need to re-think our assessments of risk. This also raises questions about what the starting point should be where there is no evidence of viral load: should we assume that an individual had a detectable viral load? Is evidence of the use of antiretroviral medication sufficient to negate this assumption?

The Manitoba Court of Appeal's decision in *Mabior* echoed the trial judge's concern that viral load reflects "a moment in time," and highlighted the fragility of evidence of viral load:

> If a person were to miss a dose of this medication, at some point, after 72 hours, an individual could become resistant to the medication, although it is uncertain how long this might take since it depends on an individual's metabolism. So, it is difficult to know one's viral load at a particular point in time and to ensure it remains undetectable. Common infections, STDs and treatment issues can lead to fluctuations in a person's viral load. HIV-positive people with apparently undetectable viral loads can experience occasional spikes in viral load or may develop viral resistance.[71]

Nevertheless, the Court of Appeal acknowledged that, given its impact on transmission rates, viral load cannot be ignored.[72] The Court of Appeal went on to look at the evidence regarding the accused's viral load for each of the counts on the indictment to determine whether the risk was significant enough

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[70] See e.g. Julio SG Montaner, "Association of Highly Active Antiretroviral Therapy Coverage, Population Viral Load, and Yearly New HIV Diagnoses in British Columbia, Canada: A Population-based Study" (2010) 376:9740 The Lancet 532.

[71] *Mabior* (CA), *supra* note 5 at para 112.

[72] *Ibid* at para 102.

to warrant criminal liability. The Court of Appeal accepted expert evidence that a spike in viral load between tests was unlikely given the accused's apparent compliance with antiretroviral therapy.

In *DC*, two medical witnesses testified at trial that the risk of a male contracting HIV from his HIV-positive female partner during vaginal intercourse is about 1 in 1,000, and, if the female's viral load is undetectable (as it was in this case), 1 in 10,000.[73] The judge nonetheless convicted the accused of aggravated assault and sexual assault because he found that the risk was sufficient for endangerment of life, even though the activity in this case was statistically very low-risk: on average, the virus would be transmitted only once in every 10,000 acts of intercourse. The trial judge did not apply the significant risk of serious bodily harm test to the consent analysis as required by *Cuerrier*. The Québec Court of Appeal overturned the conviction, finding that the undetectable viral load and low risk of transmission did not reach the threshold of significant risk of serious harm and, thus, that non-disclosure did not vitiate consent:

> À la réflexion, j'estime qu'en l'espèce, le risque de transmission du VIH était si faible qu'il ne constituait pas « un risque important de préjudice grave » pour le plaignant et qu'en conséquence, le fait pour l'appelante de ne pas avoir informé ce dernier de son état de santé ne peut pas avoir vicié son consentement à une relation sexuelle non protégée.[74]

The *Cuerrier* test forces courts and juries to weigh in on the developing science of viral load and its impact on transmission rates. It also presents a dilemma: accused persons who have access to antiretroviral medication and viral load test results will be more likely to get an acquittal than those who do not.[75] This also raises difficult questions about culpability. Is the degree of risk strictly a matter of whether the *actus reus* has been established, or is the accused's knowledge of his or her viral load and the impact that viral load has on the risk of transmission also relevant? If an accused with an undetectable viral load had no idea that it was relevant to transmission, he or she could nonetheless be acquitted because the *actus reus*–a significant risk of serious bodily harm–would

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[73] *DC* (CQ), *supra* note 28 at para 179 (where the female's viral load is undetectable, and a condom is used, the risk was reported to be 1 in 50,000).

[74] *DC* (CA) *supra* note 4 at para 100.

[75] In *Wright*, *supra* note 4 at para 33, for example, in the absence of clear evidence as to viral load the accused's viral load was presumed to be detectable, despite some evidence that the accused was taking antiretroviral medication. The accused had developed serious side effects consistent with that medication.

not be present. A more difficult case arises if the accused wrongly believed that his or her viral load rendered them non-infectious. The non-disclosure cases to date have said very little about the fault component of these very serious crimes and how fault relates to the significant risk of serious harm requirement.[76] The only explicit fault requirement discussed in these cases has been knowledge of one's HIV-positive status, and in *Williams*, the Supreme Court suggested that being "aware of the risk" that one is HIV-positive is sufficient to establish recklessness.[77] Little attention has been paid to whether the bodily harm was reasonably foreseeable in the circumstances.[78] It is certainly arguable that such harm is not foreseeable where a condom is used carefully, where the accused has an undetectable viral load, and, especially, where both are true.

C. Nature of Sexual Activity

We are now aware that different sexual activities, all other factors being equal, have very different risk levels. Oral sex, for example, is considered low risk. In *Edwards*, the Crown acknowledged that charges would not have been laid for oral sex alone.[79] Nevertheless, in *R v Aziga*, the accused was convicted on one count of aggravated sexual assault on the basis of unprotected oral sex alone where the virus was allegedly transmitted.[80]

Unprotected anal intercourse is commonly acknowledged to be a high risk activity. However, the risk for an HIV-negative *receptive* partner is significant-

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[76] The trial judge in *Mabior* considered the accused's mental state with respect to his viral load: "even if the accused had been told that his viral load was under control, that does not translate to knowledge that his ability to transmit the disease was low. …The accused did not know that he could not transmit during this timeframe" (*supra* note 37 at para 133). It is unclear from the judgment what impact this had on the judge's finding that consent had been vitiated, and it was not discussed by the Court of Appeal.

[77] In *R v Willams*, 2003 SCC 4 at para 28, [2003] 2 SCR 134 [*Williams*] the Court did not address foreseeability of harm: "Once an individual becomes aware of the risk that he or she has contracted HIV, and hence that his or her partner's consent has become an issue, but nevertheless persists in unprotected sex that creates a risk of further HIV transmission without disclosure to his or her partner, recklessness is established."

[78] *R v Godin*, [1994] 2 SCR 484 imposes an objective standard of fault for the consequences.

[79] *Edwards*, *supra* note 26.

[80] *R v Aziga*, (1 April 2009) CR081735 at 71-74 (Charge to jury).

ly greater than the risk for an HIV-negative *insertive* partner. In *R v JT*,[81] the accused failed to disclose his HIV-positive status to his male partner. The two engaged in anal intercourse and the HIV-positive accused was always the receptive partner. Evidence at the preliminary inquiry indicated that the risk of transmission in this particular case was approximately 1.5 in 10,000 for each act of unprotected intercourse. The accused was ordered to stand trial and sought to quash the committal on the basis that the Crown failed to provide any evidence of a significant risk of serious harm because the risk of transmission to an insertive partner is so low. The Canadian HIV/AIDS Legal Network intervened and argued that non-disclosure should not be criminalized where the infected individual uses a condom *or* where the risk is equally low for some other reason, such as low viral load or the role of each partner in the sexual activity:

> The Interveners ask that this Honourable Court clarify that, as a matter of Canadian law, non-disclosure of HIV-positive status to a sexual partner does not constitute a criminal offence where the risk is reduced through the use of a condom for penetrative anal or vaginal sex or in analogous circumstances where the risk is comparably low or lower than that benchmark.[82]

The British Columbia Court of Appeal rejected the argument that *Cuerrier* set a benchmark and held that risk must be assessed in individual cases. The Court of Appeal noted that anal intercourse without a condom is a high risk activity without assessing whether the infected individual is the receptive or insertive partner, a fact which has been found to alter the risk considerably.[83]

When this case went back to trial on its merits, the trial judge found that the risk was between 1.5 in 10,000 (according to the expert at the preliminary inquiry) and 4 in 10,000 (according to the expert at trial) for each act of unprotected intercourse. The risk is cumulative, such that if there were (as found by the trial judge) three acts of unprotected sex, the risk would be between 4.5 and 12 in 10,000. The expert evidence also suggested that the risk of an HIV-positive receptive partner passing on the virus to the non-infected insertive partner was approximately the same as the risk of *protected* sex where the insertive partner is HIV-positive. The respective roles of the parties involved in sexual activity were thus as significant as whether a condom was used. The trial judge held that this risk was not significant enough to meet the *Cuerrier* test and acquitted the accused.

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[81] *JT*, *supra* note 29.

[82] *Ibid* at para 16.

[83] See e.g. Baggaley, White & Boily, *supra* note 10.

Clearly, if courts are looking at viral load and condom use as relevant to risk, the type of sexual activity involved must be part of the equation, as it has a similarly significant impact on the level of risk.

D. The Numbers Game

The movement away from using protected intercourse as the clear dividing line between criminal and non-criminal conduct–and the emergence of factors such as viral load–has led to a more individualized (some might say *ad hoc*) approach to risk analysis. By and large, courts have increasingly relied on expert evidence to provide them with numerical assessments of the risk of transmission associated with specific conduct. This carries with it all the problems associated with reliance on expert witnesses. Depending on the availability of experts to the Crown and the defence, courts hear different evidence and receive different evaluations of risk. Some experts are unwilling to estimate the specific risk of the conduct of a particular accused, while others are willing to provide an individualized probability of transmission. At the retrial of *R v Nduwayo*, the expert witness declined to provide a numerical assessment of risk, instead asking the court, "[i]s that a risk you would like to take?"[84] The figures provided to the courts for the average risk vary as research and scientific knowledge of transmission develops. Finally, once provided with a numerical estimate of risk, courts have come to different decisions as to what figure is "significant."

It is left to triers of fact to digest sometimes conflicting expert evidence and then assess whether a particular risk of bodily harm is significant. It is not unusual for triers of fact to have to evaluate risks like 4 in 10,000,[85] or 1 in 200.[86] Do these numbers really inform our assessment of whether someone should be convicted of one of our most serious crimes? Should it matter whether the risk materialized?

In *R v Jones*,[87] where the accused was charged after failing to disclose that he had hepatitis C, a risk of transmission of 1 in 100 to 2.5 in 100 was found to be below the level required to constitute a significant risk:

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[84] *R v Nduwayo*, 2010 BCSC 1277 at para 136, [2011] BCWLD 1457, [2010] BCJ No 1787 (QL).

[85] *JT*, *supra* note 29.

[86] *Wright*, *supra* note 4 at para 24.

[87] *Jones*, *supra* note 8.

> For Hepatitis 'C' in monogamous heterosexual couples, the risk of transmission is less than 1%. The risk increases for those engaging in anal sex to between 1-2.5% ... I find that in the case of Hepatitis 'C' the risk of contracting it through unprotected sex is so low that it cannot be described as significant. Therefore, the positive duty to disclose does not arise.[88]

This conclusion was probably influenced by the description of the risk as "very low" by experts.[89] In addition, because the disease is blood-borne and only sexually transmitted if there is blood-to-blood contact, the risk likely appeared more remote to the judge than the percentage figure indicates. In *Jones*, the expert compared Hepatitis C with HIV and said that, by contrast, the risk of transmitting HIV is high.[90] In fact, the risk of 1-2.5 in 100 deemed insignificant in *Jones* is on par with–or higher than–the risk identified as significant in any of the HIV transmission cases for similar sexual activities.

In *DC*, the trial judge convicted the accused of aggravated assault and sexual assault notwithstanding a risk of 1 in 10,000. The trial court essentially found that any risk of transmission, however remote, is sufficient because the potential harm is seen as so great. The Québec Court of Appeal recently overturned this finding and acquitted the accused because the risk of transmission was so low as to be insignificant.[91] The facts of *DC* highlight the potential for problematic exercise of prosecutorial discretion, particularly in charging decisions. After the accused disclosed her HIV positive status to the complainant, the couple continued their relationship for four years, engaging in protected sex. It was not until after the relationship ended, and the complainant was convicted of assaulting the accused in separate proceedings, that he went to police about the one alleged incident of unprotected sex that had taken place four years earlier. The accused was charged with aggravated assault and sexual assault even though the virus was undetectable and the risk of transmission was approximately 1 in 10,000.[92] This case demonstrates why prosecutorial guidelines are essential in this context. What is to be gained in prosecuting this woman for one isolated incident of non-disclosure, followed by disclosure and ongoing protected sex, especially where the risk of transmission was so low?

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[88] *Ibid* at paras 26, 33.

[89] *Ibid* at para 23.

[90] *Ibid* at para 25.

[91] *DC* (CA), *supra* note 4.

[92] *Ibid*.

DC also raises the problem of disclosure for women in potentially abusive relationships.[93]

In *Mabior*, as discussed above, the trial judge found that even with the use of a condom, someone with a detectable viral load represented a significant risk to his sexual partner. She relied on expert evidence that condoms reduce the risk of transmission by 80%, but without examining the ramifications of that figure for the numerical assessment of risk.[94] The Manitoba Court of Appeal corrected this error, acknowledging that the trial judge's finding that any risk of transmission is too high was inconsistent with the *Cuerrier* test. The Court of Appeal also acknowledged the discrepancies between the numbers that different courts have assessed as significant; nevertheless, "it was not seriously disputed … that unprotected sexual intercourse with an individual with an unrepressed viral load constitutes a significant risk of serious bodily harm even though, from an absolute statistical point of view, the risk is small."[95]

Wright highlights the different ways in which experts assess risk and the resulting problems when courts rely on such numerical analyses. In *Wright*, the expert witness did not identify particular factors most relevant in assessing the risk of transmission, focusing instead on the wide range of circumstances included in the average calculations of risk.[96] He refused to estimate the specific risk for the conduct undertaken by the accused and relied on averages, stating that "the risk of HIV infection by a woman from vaginal intercourse with a male who is HIV-positive is between 0.1% and 1.0%; so the experts generally say the risk of transmission is 0.5%."[97] While stressing the unreliability of re-

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[93] See Patricia Allard, Cecile Kazachkine & Alison Symington, "Criminal Prosecutions for HIV Nondisclosure: Protecting Women from Infection or Threatening Prevention Efforts?" in Jacqueline Gahagan, ed, *Women and HIV Prevention in Canada: The Past, The Present and the Future: Implications for Research, Policy and Practice* (Toronto: Canadian Scholars' Press, forthcoming in 2012) [Copy on file with author]; Alison Symington, "HIV Exposure as Assault: Progressive Development or Misplaced Focus?" in Elizabeth Sheehy, ed, *Sexual Assault Law, Practice & Activism in a Post-Jane Doe Era* (Ottawa: University of Ottawa Press, forthcoming in 2011) online: University of Ottawa <www.ruor.uottawa.ca/en/handle/10393/19876>.

[94] *Mabior* (QB), *supra* note 37 at para 116. See also Grant, "Rethinking Risk," *supra* note 38.

[95] *Mabior* (CA), *supra* note 5 at para 154.

[96] *Wright*, *supra* note 4 at paras 26-27.

[97] *Ibid* at para 8.

porting on condom use, he testified that condoms reduce the transmission risk to 1 in 10,000.[98]

Although the expert in *Wright* acknowledged that a low viral load can reduce the risk of transmission between 100 and 1,000 times, he stated that viral load is only one of many factors that feed into the average risk of 1 in 200.[99] This contrasts significantly with experts in other cases who are willing to assess the particular risk more precisely, and to identify the specific factors they consider most influential in altering risk.[100] The jury in *Wright* found that the average risk of 0.5% was significant enough to warrant criminal liability.

In contrast with *Wright*, the expert at the preliminary hearing in *JT* identified three central factors in the rate of HIV transmission: the type of sex act, viral load, and co-infection with other illnesses.[101] As stated above, the expert at trial estimated the risk to the complainant at 4 in 10,000 per act of unprotected intercourse, for a cumulative risk of 12 in 10,000 for three acts of unprotected sex over the course of their relationship.[102] The trial judge found that a risk of 12 in 10,000 was not significant enough to negate consent.[103]

The cases reveal, at best, the lack of precision in assessing risk and, at worst, blatant inconsistency regarding the acceptable level of risk. The trial decision in *JAT* and the appellate decisions in *Mabior* and *DC* reflect a growing awareness that not every risk of transmission warrants criminal liability; some risks are too remote to meet the *Cuerrier* test. Nonetheless, there is still the potential in Canada for cases that extend criminalization beyond its appropriate reach. The statistical estimates offered by experts concerning condoms, viral load, circumcision, and various sexual practices will continue to confound judges and juries, and may never offer the level of precision necessary to discharge the "beyond a reasonable doubt" burden in criminal law.

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[98] *Ibid* at para 11.

[99] *Ibid* at para 27.

[100] See e.g. *JT*, *supra* note 29.

[101] *Ibid* at para 9.

[102] *Ibid* at paras 29-31.

[103] Empirical data reveals men involved in heterosexual sex have a higher rate of prosecution: Eric Mykhalovskiy, Glenn Betteridge & David McLay, *HIV Non-disclosure and the Criminal Law: Establishing Policy Options for Ontario* (Toronto: Ontario HIV Treatment Network, 2010) at 12 online: CATIE <www.catie.ca/pdf/Brochures/HIV-non-disclosure-criminal-law.pdf >.

III. What Can We Learn from Other Jurisdictions?

Not all jurisdictions have taken the approach that non-disclosure constitutes fraud negating consent to sexual activity. In fact, in England and Wales, New Zealand, and Australia, transmission or exposure in the context of non-disclosure is not dealt with as a sexual offence, but rather as an offence involving bodily harm.[104] The purpose of the following brief review is to demonstrate alternatives to the regime in Canada by highlighting aspects of the law in each jurisdiction.

A. England and Wales

There are an estimated 86,500 people living with HIV in the United Kingdom.[105] As of October 2010, there have been approximately 17 prosecutions in England and Wales. Fifteen accused were men and two were women. Thirteen of 17 accused were convicted, 11 of those convictions resulted from guilty pleas. Three of the prosecutions involved men having sex with men; the other 14 involved heterosexual transmission.[106]

In England and Wales, the criminal law punishes intentional and reckless transmission of HIV. Non-disclosure of one's HIV-positive status does not vitiate consent to sex, and individuals convicted for intentional or reckless transmission are rarely treated as sex offenders.[107] Transmission is prosecuted

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[104] Switching to offences focusing on bodily harm still leaves open the potential for overcharging with offences such as murder and attempted murder. See e.g. Adam McDowell, "Public safety trumps privacy in Ottawa HIV case" *The National Post* (27 July 2010) [Copy archived with *MJLH*] (charges against an Ottawa man include two counts of attempted murder along with several counts of aggravated sexual assault; attempted murder is a difficult charge to prove because an intent to kill–and not mere recklessness–must be established).

[105] Health Protection Agency, *HIV in the United Kingdom: 2010 Report* (2010) 4:47 Health Protection Reports 1, online: <www.hpa.org.uk/hivuk2010> [*UK HPA Report*] (A quarter of these are undiagnosed).

[106] National AIDS Trust, "Criminal Prosecution Case Table" (October 2010), online: <www.nat.org.uk> [NAT, "Case Table"].

[107] In England and Wales, it remains open on sentencing to issue offenders with a Sexual Offence Prevention Order, as was done in two cases, pursuant to the *Sexual Offences Act 2003* (UK), 2003 c 42, s 104. See NAT, "Case Table", *ibid*; *R v Hornett*, [2009] EWCA Crim 1742.

under one of two provisions of the *Offences Against the Person Act, 1861*.[108] Section 18 of the *Act* criminalizes intentional infliction of harm:

> 18. Whosoever shall unlawfully and maliciously by any means whatsoever wound or cause any grievous bodily harm to any person ... with intent ... to do some ... grievous bodily harm to any person, or with intent to resist or prevent the lawful apprehension or detainer of any person, shall be guilty of felony, and being convicted thereof shall be liable ... to be kept in penal servitude for life ...

Because of the difficulty of proving that someone actually intended to transmit HIV through sex (as opposed to intending to have unprotected sex), no charges under section 18 have proceeded to trial.[109] A person could theoretically be charged with attempted intentional transmission where no transmission occurs, but there are currently no such cases; again this is probably due to the high fault requirement. The cases thus far have all proceeded under section 20, which criminalizes the reckless infliction of bodily injury:

> 20. Whosoever shall unlawfully and maliciously wound or inflict any grievous bodily harm upon any other person, either with or without any weapon or Instrument, shall be guilty of a Misdemeanor, and being convicted thereof shall be liable … to be kept in penal servitude …

The maximum sentence for this offence is five years imprisonment.[110] The most important fact to note is that only cases that involve actual transmission are prosecuted under this provision.

In 2008, the Crown Prosecution Service in England and Wales published policy guidelines for prosecuting sexual transmission of an infection.[111] These guidelines are not legally binding but rather provide direction to prosecutors

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[108] *Offences Against the Person Act*, *1931* (UK), 24 & 25 Geo V, c 100 ss 18, 20.

[109] Catherine Dodds et al, "Responses to Criminal Prosecutions for HIV Transmission Among Gay Men with HIV in England and Wales" (2009) 17:34 Reproductive Health Matters 135 at 137. See also NAT, "Case Table", *supra* note 106.

[110] *Penal Servitude Act*, 1891 (UK), 54 & 55 Geo V, c 69, s 1(1); *Criminal Justice Act, 1948* (UK), 11 & 12 Geo V, c 58, s 1(1). The general sentence for many crimes was set out in the *Penal Servitude Act*; these sentences were modified by the *Criminal Justice Act*, which replaced penal servitude (hard labour) with mere imprisonment.

[111] The Crown Prosecution Service, "Policy for Prosecuting Cases Involving the Intentional or Reckless Sexual Transmission of Infection", online: CPS <www.cps.gov.uk/publications/prosecution/sti.html> ["England Crown Policy"].

regarding which cases should be prosecuted. The guidelines demonstrate that England and Wales take a much more cautious approach to prosecuting these offences than does Canada. For example, the prosecutorial guidelines suggest that only a sustained course of conduct warrants a charge of reckless transmission:

> It will be highly unlikely that the prosecution will be able to demonstrate the required degree of recklessness in factual circumstances other than a sustained course of conduct during which the defendant ignores current scientific advice regarding the need for and the use of safeguards, thereby increasing the risk of infection to an unacceptable level.[112]

According to the guidelines, recklessness is not about non-disclosure (although consent may be raised as a defence by asserting that disclosure was made), rather, it involves assessing the accused's behaviour against the medical advice he or she received. The following passage suggests that the use of safeguards, such as a condom, might also negate recklessness. Condoms are not raised directly in the guidelines, but one can infer that prosecution should only be initiated for unprotected sex:

> Evidence that the defendant took appropriate safeguards to prevent the transmission of the infection throughout the entire period of sexual activity, and evidence that those safeguards satisfy medical experts as reasonable in light of the nature of the infection, will mean that it will be highly unlikely that the prosecution will be able to demonstrate that the defendant was reckless.[113]

The guidelines go on to suggest that if the accused believed that the safeguards were reasonable, recklessness will be hard to establish:

> Although infection can occur even where reasonable and appropriate safeguards have been taken, it is also of course possible that the infection took place because the safeguards and/or their use or application were inappropriate. However, prosecutors will need to take into account what the defendant considered to be the adequacy and appropriateness of the safeguards adopted; *only where it can be shown that the defendant knew that such safeguards were inappropriate will it be likely that the prosecution will be able to prove recklessness.*[114]

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[112] *Ibid.*

[113] *Ibid.*

[114] *Ibid* [emphasis added].

These requirements, if followed, suggest that protected sex is extremely unlikely to lead to prosecution in England and Wales.[115]

Because only cases of actual transmission are prosecuted, causation is a critical issue. The Crown must prove that the complainant acquired the virus from the accused. Prior to 2006, phylogenetics was often used to support causation. Phylogenetics is a scientific technique that determines whether the strain of the virus carried by the complainant is the same as, or similar to, the strain carried by the accused. This evidence has prompted some accused to enter guilty pleas and has sometimes been misunderstood as providing proof of causation.[116] Phylogenetics, however, shows the genetic similarity between viruses but provides no evidence of the direction of transmission (i.e. who transmitted the virus to whom). In a 2006 case, the accused was acquitted because phylogenetics was found to be inadequate to prove causation.[117] Since this case, there have been no successful prosecutions where the accused has pled not guilty; there have been five guilty pleas and three acquittals.[118]

English prosecutorial guidelines reflect the inconclusive nature of phylogenetics:

> However, scientific and medical evidence will only ever form part of the case against the defendant. We must build up a strong factual case around the scientific and medical evidence in order to satisfy the evidential test in the Code. This is because scientific and medical evidence of this nature is not as precise as, for example, evidence of DNA matches.[119]

The two leading cases in England and Wales are *R v Dica*[120] and *R v Konzani*,[121] both of which were decided before the prosecutorial guidelines were developed. Dica was convicted at his second trial of one of two counts of reck-

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[115] It is possible that a prosecution could take place where a condom was used if the virus was still transmitted, but I have been unable to find any such cases.

[116] EJ Bernard et al, "HIV Forensics: Pitfalls and Acceptable Standards in the Use of Phylogenetic Analysis as Evidence in Criminal Investigations of HIV Transmission" (2007) 8:6 HIV Medicine 382 at 386.

[117] Michael Carter, "Prosecution for Reckless HIV Transmission in England Ends With Not Guilty Verdict" (9 August 2006) online: AIDSmap <www.aidsmap.com/page/1424549/>.

[118] NAT, "Case Table", *supra* note 106.

[119] "England Crown Policy", *supra* note 111.

[120] *R v Dica*, [2004] EWCA Crim 1103 at para 39, [2004] Crim LR 944 [*Dica*].

[121] *R v Konzani*, [2005] EWCA Crim 706, [2005] 2 Cr App R 198 [*Konzani*].

lessly inflicting grievous bodily harm, contrary to section 20 of the *Offences Against the Person Act, 1861*. Both of the female complainants were HIV-positive. Dica's original conviction was overturned on appeal because the trial judge had erred in disallowing the defence of consent to the risk of potential harm flowing from sexual activity. Out of a desire to avoid criminalizing the consensual taking of risks, the English Court of Appeal found that consent could operate as a defence in the context of reckless transmission, if the complainant consented to the risk of infection (even though non-consent was not, strictly speaking, an element of the offence). While disclosure is not the only way to show consent, it is the most likely way to raise the defence.[122] The Court of Appeal also stated that if a condom had been used, it would have gone to the assessment of recklessness by the trier of fact. The Court of Appeal in *Dica* also suggested that liability applies to those who "know that they are suffering HIV or some other serious sexual disease,"[123] suggesting it is not sufficient to know that one could be HIV-positive.[124]

Konzani was convicted of three counts of recklessly inflicting grievous bodily harm on three female complainants, all of whom had contracted HIV. Konzani argued that by engaging in unprotected intercourse with him, the complainants impliedly consented to any possible attendant risks, including the risk of contracting HIV. The English Court of Appeal rejected this argument on the ground that consent must be informed.[125]

It is clear that criminalizing only actual transmission will greatly reduce the number of prosecutions. Further limits on prosecution established by the prosecutorial guidelines, such as the use of reasonable safeguards, have resulted in a relatively low level of prosecution in England and Wales as compared to Canada. As demonstrated in the following section, New Zealand has taken a slightly different approach.

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[122] As Weait points out there may be other ways that a person has knowledge of an accused's HIV status without disclosure. Furthermore, he would argue that there is always the risk of acquiring HIV in unprotected sex and that the complainant is equally responsible for failing to use a condom: Matthew Weait, "Criminal Law and the Sexual Transmission of HIV: *R v Dica*" (2005) 68:1 Mod L Rev 121. See also Matthew Weait, "Taking the Blame: Criminal Law, Social responsibility and the Sexual Transmission of HIV" (2001) 23:4 J of Soc Welfare & Fam L 441.

[123] *Dica*, *supra* note 120 at para 59.

[124] Because Dica did in fact know his HIV-positive status, it wasn't strictly necessary for the Court to decide this point.

[125] *Konzani*, *supra* note 121 at para 42.

B. New Zealand

As of 2009, there were an estimated 2,500 people living with HIV in New Zealand.[126] As of December 2008, there have been at least seven prosecutions for non-disclosure with six convictions; all the accused have been men.[127] In New Zealand, there are three potential levels of liability, depending on fault and whether transmission occurred. Section 201 of the *Crimes Act, 1961* criminalizes the intentional transmission of a disease and is applicable where HIV is intentionally transmitted:

> (1) Every one is liable to imprisonment for a term not exceeding 14 years who, wilfully and without lawful justification or excuse, causes or produces in any other person any disease or sickness.[128]

There have not been any successful prosecutions for intentional sexual transmission under this section because of the high fault requirement.[129]

Where the virus is recklessly transmitted, section 188 is the most likely charge:

> (2) Everyone is liable to imprisonment for a term not exceeding 7 years who, with intent to injure anyone, or with reckless disregard for the safety of others, wounds, maims, disfigures, or causes grievous bodily harm to any person.

The courts have held that non-disclosure in the context of unprotected vaginal intercourse satisfies the recklessness criterion.[130] The New Zealand Court of Appeal in *Mwai* held that infection with HIV constitutes grievous bodily harm because of the seriousness of the resulting disease and its consequences, but limited the ambit of grievous bodily harm to infection with serious diseases.[131]

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[126] UNAIDS, "New Zealand", online: UNAIDS <www.unaids.org/en/regionscountries/countries/newzealand/> .

[127] Global Criminalisation Scan, "New Zealand", online: GCS <www.gnpplus.net/criminalisation/index.php?option=com_content&task=view&id=244&Itemid=47>.

[128] (NZ), 1961/43 [*Crimes Act* (NZ)].

[129] Amelia Evans, "Critique of the Criminalisation of Sexual HIV Transmission" (2007) 38:3 Victoria U Wellington L Rev 517.

[130] *R v Mwai*, [1995] 3 NZLR 149 (CA) [*Mwai*].

[131] *Ibid* at 153.

Where sex, without disclosure, does not result in transmission of the virus, the much less serious offence of criminal nuisance (section 145) is utilized, which carries a maximum sentence of one-year imprisonment:

> (1) Every one commits criminal nuisance who does any unlawful act or omits to discharge any legal duty, such act or omission being one which he knew would endanger the lives, safety, or health of the public, or the life, safety, or health of any individual.[132]

The Court of Appeal in *Mwai* found that the legal duty in question is the common law duty not to expose others to foreseeable harm.[133] There is also a statutory duty set out in section 156. Although *Mwai* did not decide whether or not the statutory duty also applies, subsequent decisions have considered the legal duty in light of the language of section 156:[134]

> [E]very one who has in his charge or under his control anything whatever … which, in the absence of precaution or care, may endanger human life is under legal duty to take reasonable precautions against and to use reasonable care to avoid such danger …[135]

If one takes "reasonable precautions" or uses "reasonable care" to avoid the harm, the accused will not be guilty of criminal nuisance. In *Police v Dalley*, the Court of Appeal held that use of a condom is a reasonable precaution.[136] On a charge relating to oral sex without a condom, the trial judge also held that, because the risk involved in oral sex without ejaculation is so low, the accused satisfied the reasonable care criterion even without taking any precautions. Thus, criminal nuisance does not encompass every instance of non-disclosure of one's HIV-positive status; there must be a sufficient level of risk to warrant criminalization.

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[132] *Crimes Act* (NZ), *supra* note 128 s 145.

[133] *Mwai*, *supra* note 130 at 156.

[134] *Dalley*, *supra* note 49 at 683-84.

[135] *Crimes Act* (NZ), *supra* note 128.

[136] *Dalley*, *supra* note 49.

C. Australia

There were an estimated 20,000 people living with HIV in Australia in 2009.[137] The Global Criminalisation Scan states that as of February 2010, 28 prosecutions had been undertaken in Australia, and 15 people had been convicted.[138] The *NAPWA Monograph* estimates slightly lower numbers, with 22 prosecutions undertaken, 12 convictions, and 3 additional instances where charges were dropped as of September 2009.[139] There has been a notable increase in prosecutions since 2007, particularly in the states of South Australia and Victoria. As in New Zealand, all accused have been male.[140]

The criminal law in Australia is under the jurisdiction of each state or territory. The law of all nine jurisdictions, with the exception of Victoria, provides that consent is not valid if given as a result of misrepresentation or fraud as to the nature of the sexual intercourse. Nevertheless, Australia has not labeled non-disclosure as fraud that vitiates consent to the sexual act, a position that avoids imposing the label "sex offender" on a person convicted of non-disclosure.[141]

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[137] UNAIDS, "Australia", online: UNAIDS <www.unaids.org/en/regionscountries/countries/australia/>.

[138] The Global Criminalisation Scan, "Australia", online: GCS <www.gnpplus.net/criminalisation/index.php?option=com_content&task=view&id=254&Itemid=70>.

[139] *The Criminalisation of HIV Transmission in Australia: Legality, Morality and Reality* (2009), online: National Association of People Living with HIV/AIDS <www.napwa.org.au> [*NAPWA Monograph*]

[140] Australasian Society for HIV Medicine, "Guide to Australian HIV Laws and Policies for Health Care Professionals: Criminal Law", online: ASHM <www.ashm.org.au/HIVLegal/Default.asp?PublicationID=2&ParentSectionID=P2&SectionID=342> [ASHM, "Guide to Australian HIV Laws and Policies"].

[141] The offence of fraud has been discussed in Australia: *R v Reid*, [2006] QCA 202, 1 Qd R 64, 162 A Crim R 377 [*Reid*]. McPherson JA, in dissent, suggested that to meet the statutory requirement that the act be 'unlawful', the offence of fraud under s 408C(1)(e), *Criminal Code 1899* (Qld) could be applied. He echoed *Cuerrier* when he said, at para 20: "[i]nducing someone to have unprotected intercourse with him by falsely representing that he was not HIV positive, while knowing that he was, seems to me to fall within the ambit of this provision. It hardly need be said that infecting someone with HIV involves causing a detriment to him or her." This suggestion was not taken up by the High Court of Australia, which refused leave to appeal on the grounds that certain exceptional "features of the evidence at trial that make this an unpromising case for this Court's intervention" (*R v Reid*,

Only three of the nine Australian jurisdictions criminalize exposure without transmission, and of those jurisdictions, two states apply different criminal offences for exposure and for transmission.[142] The remaining six jurisdictions do not prosecute exposure where no transmission has occurred.

In Victoria, where most of the prosecutions have taken place, "conduct endangering life"[143] is charged if transmission occurs, and "conduct endangering persons"[144] is charged if transmission does not occur:

> 22. A person who, without lawful excuse, recklessly engages in conduct that places or may place another person in danger of death is guilty of an indictable offence. Penalty: Level 5 imprisonment (10 years maximum).
>
> 23. A person who, without lawful excuse, recklessly engages in conduct that places or may place another person in danger of serious injury is guilty of an indictable offence. Penalty: Level 6 imprisonment (5 years maximum).[145]

Early cases distinguished between these offences by assessing the risk of potential harm;[146] however, both offences were charged in cases of non-transmission until 1998, when the accused in *Mutemeri* successfully challenged the assertion that exposure without transmission constituted a risk of

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2006 HCATrans 666, online: AusLII <www.austlii.edu.au/au/other/HCATrans/2006/666.html>).

[142] *Crimes Act 1958* (Vic), ss 22-23 [*Crimes Act* (Vic)]; *Criminal Law Consolidation Act 1935* (SA) s 29 [*CLCA* (SA)]; *Criminal Code* (NT), ss 174C, 174D [*Criminal Code* (NT)]. I am assuming for the purposes of this paper that the legislation in the Northern Territory allows for criminalization of mere exposure although there have been no cases to date clarifying this interpretation

[143] *Crimes Act* (Vic), *ibid* s 22.

[144] *Ibid* s 23.

[145] *Ibid* ss 22-23.

[146] *R v B* (3 July 1995), unreported judgment (Vic SC (Crim Div)), Teague J established that exposure without transmission of HIV was insufficient because the offence in s 22 required an "appreciable danger of death," rather than death being a "remote" or "mere" possibility (cited in *Mutemeri v Cheesman*, [1998] 4 VR 484 at 489, 100 A Crim R 397 [*Mutemeri* cited to VR]).The judge found that the risk of transmitting HIV through unprotected anal intercourse, estimated in that case to be 1 in 200 or less, was remote. In a subsequent case, *R v D* (1 May 1996), unreported judgment (Vic SC), Hampel J agreed with the holding in *R v B* that the risk should be an "appreciable" one (cited in *Mutemeri* at 489).

death.[147] Mutemeri was initially convicted of 12 counts under section 22 for having unprotected sex with a woman who did not contract HIV. On appeal, the Supreme Court of Victoria found that the magistrate was not entitled to find, without evidence, that the accused's conduct exposed the complainant to an appreciable risk of death.[148] Justice Mandie in *Mutemeri* formulated the test as follows: "In addition to the subjective intent to engage in the conduct coupled with recklessness as so defined, … [there must be] the objective intent of the reasonable person … which involves realisation by a reasonable person that the conduct would (or might) place another in danger of death."[149] Justice Mandie also commented that he had "some doubt as to whether the offence created by section 22 of the *Crimes Act* is properly to be construed as applicable to cases other than those where a person is exposed to the risk of a death of some immediacy or imminence."[150]

South Australia is the only Australian jurisdiction where the same offence is charged regardless of whether transmission occurred or not. This is in large part due to judicial formulation of the test for endangerment of life. The offence is set out in section 29 of the *Criminal Law Consolidation Act 1935* (SA):

> 29. (1) Where a person, without lawful excuse, does an act or makes an omission—
>
> (a) knowing that the act or omission is likely to endanger the life of another; and
>
> (b) intending to endanger the life of another or being recklessly indifferent as to whether the life of another is endangered, that person is guilty of an offence.[151]

In *R v Parenzee*,[152] the first case in South Australia to consider the non-disclosure of HIV, the Supreme Court rejected the accused's argument that "likely" in paragraph 29(1)(a) should be interpreted to mean more probable than not, thus creating a threshold of risk for culpability. Chief Justice Doyle found that the risk should be a real or substantial threat to life.[153] Justice Bleby

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[147] *Mutemeri*, *ibid*.

[148] *Ibid* at 484, 491.

[149] *Ibid* at 491.

[150] *Ibid* at 493.

[151] *CLCA* (SA), *supra* note 142 s 29.

[152] *R v Parenzee*, [2008] SASC 245 [*Parenzee*].

[153] *Ibid* at paras 73, 79 (dissenting in the result but on different issues).

pointed out that "the object of the likelihood [is] endangering life. It is not causing death nor is it, in this case, the likelihood of the victims contracting HIV."[154] He rephrased the test as follows: "life is endangered if it can be said that it is a reasonable possibility that death will ensue as a result of that unprotected act of sexual intercourse."[155] Despite these different formulations of the test, all three judges agreed that there was evidence on which the jury was entitled to find that engaging in unprotected sexual intercourse exposed the complainants to sufficient risk, whether transmission occurred or not.

The issue of condom use is a relevant consideration in the three Australian jurisdictions that criminalize exposure without transmission (Victoria, South Australia, and the Northern Territory). As no charges have been laid for non-disclosure where condoms were used–and no charges have been laid in the Northern Territory at all–the effect of condom use on culpability has not been clearly addressed. Nevertheless, in passing, judicial decisions have referred only to unprotected sex as culpable.[156] This approach accords with the Australian public health message emphasizing protected sex, which has been remarkably successful in preventing the spread of HIV.[157]

Few courts in Australia have had occasion to confront numerical assessments of risk. Where they have done so, they have considered the numerical risk to be low. In *R v B*, one of the first cases tried in Victoria, the judge found that the risk of transmitting HIV through unprotected anal intercourse, estimated in that case to be 1 in 200 or less, was remote.[158] In *R v D*, a risk of 1 in 1,000 to 1 in 2,000 was also seen as insufficiently high.[159]

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[154] *Ibid* at para 152.

[155] *Ibid* at para 155.

[156] See e.g. *R v Kuoth* [2010] VSCA 103 ("the appellant had been ordered … to divulge his HIV positive status to any sexual partners and to use condoms during sexual intercourse. The fact that so soon afterwards he proceeded to disobey both aspects of that order is, of course, reflected in the charges which were laid" at para 5). For a South Australian example, see *Parenzee*, *supra* note 152 at para 18 where the trial judge charged the jury that "[t]he following elements must be proved beyond reasonable doubt. Firstly, the accused did an act or acts, namely, that he had unprotected sexual intercourse."

[157] *NAPWA Monograph*, *supra* note 139 at 19.

[158] *R v B*, *supra* note 146 at para 5.

[159] *R v D*, *supra* note 146 at para 5. Victorian cases no longer turn on the assessment of risk, as different offences are charged for transmission and exposure.

D. Comparing Canada to England and Wales, New Zealand, and Australia

When one compares Canada to England and Wales, New Zealand, and Australia, several facts stand out. Perhaps most notable is the high number of prosecutions in Canada compared to the other jurisdictions. Over 100 prosecutions have been documented in Canada as compared to 17 in England and Wales, 7 in New Zealand, and between 22 and 28 in Australia.

The other striking difference–which is likely related to the first–is that in England and Wales, and in six of Australia's nine jurisdictions, cases are only prosecuted if transmission of the virus has occurred. In New Zealand and two Australian jurisdictions (Victoria and the Northern Territory), a different offence is used depending on whether the virus is transmitted. In New Zealand, for example, the relatively minor offence of criminal nuisance is used where no transmission takes place, subjecting the accused to a maximum one year of imprisonment. Of all the jurisdictions considered in this paper, South Australia is the only one which has taken the Canadian approach of punishing exposure and transmission with the same offence.[160] In Canada, the same charge of aggravated (sexual) assault is typically used regardless of the nature of the deception, whether the virus is transmitted, or whether there is an isolated incident of non-disclosure or an ongoing course of non-disclosure. It is also notable that Canada is the only jurisdiction of those discussed that explicitly labels the accused as a sex offender due to the non-disclosure. In all other jurisdictions, the offence is characterized as the infliction of bodily harm, and not as non-consensual sexual contact.[161] These jurisdictions reveal that the *Cuerrier* approach is by no means the only way to address the criminalization of non-disclosure. In fact, the current Canadian approach is anomalous when compared to other Commonwealth jurisdictions.

The assessments of risk that have accompanied the criminalization of exposure without transmission in Canada have led some courts to find liability where the risk involved was extremely small. In Canada, a risk as low as 1 in

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[160] Only one case in South Australia (*Parenzee*, *supra* note 152) held that both exposure and transmission are captured under the offence of "acts endangering life or creating risk of serious harm" (*CLCA* (SA), *supra* note 142 s 29). Regardless, no charges have yet been successfully prosecuted for exposure alone, although some cases are pending.

[161] Although in England and Wales this does not rule out a Sexual Offence Prevention Order (*Sexual Offences Act*, *supra* note 107).

10,000 has been found to constitute significant risk of bodily harm.[162] Contrast this with the risks of 1 in 200[163] and 1 in 1,000 to 1 in 2,000 found to be insufficient for criminal liability in the Australian state of Victoria.[164] Although the assessment of risk is a question of fact in each case, it is striking that Canadian judges have reacted so harshly to risks that are too low to justify criminalization elsewhere.

IV. Is *Cuerrier* the Problem?

While some of the trial judgments to date leave room to find that any risk of transmitting HIV is sufficient to ground liability, the Manitoba Court of Appeal in *Mabior*, the Québec Court of Appeal in *DC*, and the trial decision in *JAT* reflect a movement towards limiting criminal liability to cases involving a real, quantifiable "significant risk of serious harm." Nevertheless, the potential for over-criminalization remains because the definition of such a risk continues to be elusive.

In her concurring minority judgment in *Cuerrier*, Justice McLachlin predicted the difficulties of applying the "significant risk of bodily harm" test:

> When is a risk significant enough to qualify conduct as criminal? In whose eyes is "significance" to be determined—the victim's, the accused's or the judge's? What is the ambit of "serious bodily harm"? Can a bright line be drawn between psychological harm and bodily harm, when the former may lead to depression, self-destructive behaviour and in extreme cases suicide? The criminal law must be certain. If it is uncertain, it cannot deter inappropriate conduct and loses its *raison d'être*. Equally serious, it becomes unfair. … Finally, Cory J.'s limitation of the new crime to significant and serious risk of harm amounts to making an *ad hoc* choice of where the line between lawful conduct and unlawful conduct should be drawn. This Court, per Lamer C.J., has warned that making *ad hoc* choices is properly the task of the legislatures, not the courts…[165]

The problems Justice McLachlin identified have been played out in the application of *Cuerrier* and invite a critical re-examination of that case. Studies also indicate that there is uncertainty amongst persons with HIV as to what behav-

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[162] *DC* (CQ), *supra* note 28 although this finding was recently reversed on appeal (*DC* (CA), *supra* note 4). See *Mabior* (CA) *supra* note 5.

[163] *R v B*, *supra* note 146 at 489.

[164] *R v D*, *supra* note 146 at 489.

[165] *Supra* note 2 at para 48.

iour is criminal and what their legal responsibilities are with respect to disclosure.[166]

There are at least two broad categories of problems relating to *Cuerrier*. First, every case of non-disclosure will inevitably be prosecuted as, at a minimum, aggravated assault or aggravated sexual assault. There is no room for lesser levels of culpability even where no bodily harm is done to the complainant or where there is only one isolated incident of non-disclosure. Second, *Cuerrier* creates uncertainty about what kinds of harm are sufficient both to negate consent and to endanger life. Because these cases have become so dependent on expert evidence and individual risk assessment, it is difficult to predict outcomes in particular cases. Even courts of appeal are wary of making definitive statements regarding viral load or condom use, leaving it to triers of fact to assess whether the level of risk is significant. [167] Thus, there is a troubling lack of predictability in an area of the law that cries out for certainty.

A. Reconsidering Aggravated (Sexual) Assault

Many HIV non-disclosure cases involve charges of aggravated sexual assault, although others, including the two leading cases from the Supreme Court of Canada,[168] involve charges of aggravated assault. It is difficult to determine how these charging decisions are being made for virtually identical conduct. This disparity may arise in part because the Court in *Cuerrier* characterized the underlying assault as a sexual assault. Thus, the addition of the aggravating circumstance logically leads to a charge of aggravated *sexual* assault, even though *Cuerrier* involved aggravated assault.

Aggravated sexual assault carries a maximum life sentence, whereas the maximum for aggravated assault is 14 years.[169] This is complicated further by the fact that aggravated sexual assault is a designated offence under section 490.011(1) of the *Criminal Code*, for the purpose of Canada's sex offender registration law,[170] whereas aggravated assault is not. This distinction has existed only since 15 December 2004, when *SOIRA* came into force, and thus

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[166] Mykhalovskiy, Betteridge & McLay, *supra* note 103 at 12.

[167] *Mabior* (CA), *supra* note 5; *DC* (CA), *supra* note 4.

[168] *Cuerrier*, *supra* note 2; *Williams*, *supra* note 77.

[169] *Criminal Code*, RSC 1985, c C-46, ss 268(2), 273(2).

[170] *Sex Offender Information Registration Act*, SC 2004, c 10, proclaimed in force 15 December 2004, SI/2004-157, (2004) C Gaz II, 2021 [*SOIRA*].

cannot fully explain the blurring of these two offences in the HIV cases.[171] While the distinction between the offences could now provide a reason for charging aggravated sexual assault (and for using aggravated sexual assault charges as a vehicle for plea bargaining down to aggravated assault), the sex offender registry does not appear to explain how and why these offences have come to be used interchangeably. It is true, however, that most, though not all recent cases appear to involve charges of aggravated sexual assault.

This paper assumes that both these charges will continue to be laid until the Supreme Court or Parliament directs otherwise. The following discussion focuses on the endangerment of life component, which is common to both of these aggravated assault offences. To simplify the discussion in this section, I use the term "aggravated assault," but with the awareness that, in many cases, aggravated sexual assault is charged.

Aggravated assault is the most serious form of assault in Canadian law. It applies to an accused who wounds, maims, disfigures, or endangers the life of the complainant in the course of an assault. Prior to the HIV transmission cases, endangerment of life applied primarily to assaults that resulted in serious physical harm–harm more significant than that covered by assault causing bodily harm.[172] Aggravated assault is a consequence crime; it requires a low level of fault because of the seriousness of the harm caused. The *actus reus* has been described as "an assault (the act)–a consequent endangering of the life of the complainant (the result)."[173] In *R v Creighton*, the Supreme Court of Canada endorsed the interpretation of endangerment as a *harm* that results from the assault.[174] Prior to *Cuerrier*, there was conflicting case law on whether endangerment of life can be established when there is no bodily harm to the victim. Although courts often stated that, in theory, endangerment of life could occur without any physical harm being caused, such statements were usually made in context of cases where serious harm had been caused and thus were not necessary for the decision.[175] This issue was addressed in *R v De Freitas*,[176] where

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[171] See e.g. *Cuerrier*, *supra* note 2; *Williams*, *supra* note 77. Both cases predated the sex offender registry.

[172] See e.g. *R v APP*, 2008 ONCJ 196, 77 WCB (2d) 117 (a boy set fire to a girl's breasts causing third degree burns; the mild scarring and possible nerve damage constituted bodily harm but was insufficient to warrant an aggravated assault conviction).

[173] *R v L(SR)* (1992), 11 OR (3d) 271, 76 CCC (3d) 502 (ONCA) [*L(SR)*].

[174] [1993] 3 SCR 3, citing *L(SR)*, *ibid* with approval.

[175] An exception to this can be found in *R v Melaragni* (1992), 75 CCC (3d) 546, 17 WCB (2d) 148 (Ont Gen Div) where the court held that the accused shooting two

the accused had attempted, unsuccessfully, to stab a police officer with a knife. He was acquitted of aggravated assault. The Manitoba Court of Appeal held that:

> The use of a weapon in an assault will almost always create a risk of the victim being wounded, maimed or disfigured or his or her life endangered. Yet the legislation does not place an assault with a weapon in the category of aggravated assault. For this to happen, the risk must become reality. The victim must actually be wounded, maimed or disfigured or his or her life endangered. 'Endangers the life of the complainant' is thus, in my view, intended to be as much a consequence of the assault as 'wounds, maims or disfigures.'
>
> …
>
> Most assaults with a weapon have such potential at their inception, but do not qualify as an aggravated assault because the potential is unrealized when the assault ends.[177]

The Court of Appeal in *De Freitas* did acknowledge that there could be instances where endangerment may be proven in the absence of harm. In particular, the Court of Appeal agreed with the examples from the trial decision in *R v Melaragni*:

> For example, if D. and V. are standing on a 20th-floor balcony and D. pushes V., causing V. to go over the railing, but V. miraculously holds on and is rescued before falling, can it be doubted that D.'s common assault endangered the life of V.? In this example, D. has assaulted V. and the assault has endangered V.'s life even though V. suffered no bodily injury. The same could be said if D. pushed V. into a busy intersection in the face of oncoming vehicular traffic. Assuming that an alert motorist was able to avoid striking V., can it be doubted that V.'s life was endangered?

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bullets into the driver's seat of a car where the victims were located could constitute aggravated assault even though the only injury caused was a small scratch to one victim. For a discussion of these cases see Ferguson, *supra* note 23 at 52-55 who takes the opposite view to the one expressed in this paper.

[176] *R v De Freitas*, [1999] 7 WWR 643 at para 12, 134 ManR (2d) 78 (CA) [*De Freitas*].

[177] *Ibid* at paras 12, 14.

> In my opinion, the assaults in those examples qualify as aggravated assaults because endangerment to life is the consequence of the completed assault.[178]

In *Cuerrier* it was assumed, without careful analysis, that bodily harm is not required to establish endangerment of life because the risk of contracting HIV was always sufficient. Justice Cory held that "it is not necessary to establish that the complainants were in fact infected with the virus. There is no prerequisite that any harm must actually have resulted."[179] Following *Cuerrier*, the Manitoba Court of Appeal in *Mabior* explicitly stated that endangering life can occur "without any bodily harm actually occurring to the victim."[180] *Cuerrier* changed the focus of aggravated assault by shifting the emphasis for endangerment from actual harm to risk of harm, even where no bodily harm to the complainant is caused. Endangering life was taken out of the context of assaults that wound, maim, or disfigure, and put into the context of harm that may not actually materialize.[181] Convicting someone who has not transmitted HIV of either of these serious consequence crimes may be overreaching the appropriate boundaries of both aggravated assault and aggravated sexual assault.

I am not suggesting that aggravated assault can never be established in the absence of bodily harm. If a person is pushed into oncoming traffic but miraculously escapes harm, the endangerment of life is direct and immediate. The endangerment of life in the non-disclosure context is much more tenuous. First, the virus must be transmitted; this is never more likely than not. Second, given our improved treatment of HIV/AIDS and life expectancies that approach normal, the endangerment of life becomes tenuous even where the virus has been transmitted. As the *Mabior* expert witness report stated, most

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[178] *Ibid* at paras 13-14, citing *Melaragni*, *supra* note 175.

[179] *Cuerrier*, *supra* note 2 at para 95.

[180] *Mabior* (CA), *supra* note 5 at para 140.

[181] The associated words rule of statutory interpretation, *noscitur a sociis*, states that "when two or more terms linked by 'and' or 'or' serve an analogous grammatical and logical function within a provision… [t]his parallelism invites the reader to look for a common feature among the terms. This feature is then relied on to resolve ambiguity or limit the scope of the terms." Ruth Sullivan, *Sullivan on the Construction of Statutes*, 5th ed (Markham: LexisNexis, 2008) at 227. Thus it could be argued that the words "endanger life" should be read in light of the words that precede it, wounding or maiming, both of which require some actual harm. The counter-argument is the presumption against tautology: Parliament does not include unnecessary language (Sullivan at 210-213).

HIV-positive people who comply with treatment will die of a cause unrelated to AIDS.[182] Where there is no transmission, the endangerment is simply too remote.

There are also compelling public policy reasons to be cautious about over-prosecution of non-disclosure[183] which do not apply to *situations* where someone is pushed off a balcony or hurled into oncoming traffic. This is not to trivialize the psychological harm to the complainant when he or she learns of the accused's HIV status. However, the harm is much greater where the complainant contracts HIV than where he or she does not. It is the increased harm that warrants labelling the assault "aggravated."

Even in *R v Williams*, in which the Supreme Court of Canada declined to find aggravated assault because it was not proven that the virus had been transmitted *after* the accused learned of his infection, the Court recognized that aggravated assault focuses on the consequences of the crime, not on the assault itself:

> Section 268(1) applies to a wide variety of human activity, and its interpretation should not be skewed to accommodate the hard facts of this case. Its focus should continue to be, as in the past, on the nature of the consequences rather than on the nature of the assault.[184]

I would argue, therefore, that aggravated assault charges should be limited to cases in which the virus is transmitted. While this is open to the criticism that transmission may be largely a matter of chance, we often differentiate degrees of culpability in criminal law by the harm caused: an assault may become manslaughter if the victim dies, even though the *mens rea* remains the same.

The *Cuerrier* analysis conflates sexual assault with aggravated sexual assault. A significant risk of serious bodily harm is required to negate consent and thus prove the crime of sexual assault. Yet once the Crown proves sexual assault, it automatically proves aggravated sexual assault as well. This is because the test for endangerment of life is virtually identical to the test for estab-

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[182] See e.g. Antiretroviral Therapy Cohort Collaboration, "Causes of Death in HIV-1-Infected Patients Treated With Antiretroviral Therapy, 1996-2006: Collaborative Analysis of 13 HIV Cohort Studies" (2010) 50:10 Clinical Infectious Diseases 1387 at 1390; *Mabior* (*CA*), *supra* note 5 at para 63.

[183] See Grant, "The Boundaries of the Criminal Law", *supra* note 6; Grant, "Rethinking Risk" *supra* note 38.

[184] *Supra* note 77 at para 58.

lishing fraud.[185] In the HIV non-disclosure context, these tests are so similar they almost always overlap. Thus, every sexual assault of this nature will constitute aggravated sexual assault because it will endanger life. The *Cuerrier* test renders conviction for lesser-included offences unlikely. There is no room for gradations of blameworthiness, as envisioned by the existence of the two offences.

Currently, accused persons are charged with one of two aggravated assault offences, virtually interchangeably. The cases run a wide gamut of culpability. In *R v DC*, there was one act of unprotected intercourse before the accused disclosed her HIV-positive status to the complainant two months after meeting him.[186] Several weeks after the disclosure, the complainant reinitiated contact and continued the relationship with the accused for four years. The relationship ended badly, and charges were subsequently laid for that one act of unprotected intercourse four years earlier. The accused's viral load was undetectable at the time of the unprotected intercourse, and the risk that she would transmit the virus to the complainant was stated to be 1 in 10,000. The complainant did not contract HIV, yet the accused was convicted of aggravated assault and sexual assault. By contrast, in *R v JML*,[187] the accused deliberately misled the complainant and went so far as to fabricate a laboratory requisition form indicating that he was HIV-negative when, in fact, he knew that he was HIV-positive. In *R v Nduwayo*, the virus was transmitted to several complainants, including one who became pregnant. [188] In another Ontario case, Carl Leone transmitted HIV to five complainants, and exposed a further ten sexual partners to the risk of contracting HIV.[189] Although differences in culpability can be taken into account in sentencing, I would argue that the most serious offence should be reserved for the most serious cases involving transmission in the context of a sustained course of conduct, such as those demonstrated by Leone and Nduwayo. Furthermore, it is time to consider whether *sexual* assault is the most appropriate charge in these cases or whether the focus should be on the harm caused by transmission and not the sexual nature of the activity that was the vehicle for transmission. An offence like unlawfully causing bodily harm, found in section 269 of the *Criminal Code*, might better capture the nature of the offence and, as a hybrid offence, has a more reasonable range of penalties

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[185] *JAT*, *supra* note 4.

[186] *DC* (CQ), *supra* note 28.

[187] 2007 BCPC 341.

[188] *Supra* note 84.

[189] "Criminal Law and HIV Transmission or Exposure: Seen New Cases" (2008) 13:1 HIV/AIDS Policy and Law 50 at 51.

to reflect the varying culpability found in these cases.[190] Alternatively, criminal negligence causing bodily harm, in section 221, is another option which focuses on the *consequence* in the context of wanton or reckless disregard for the life or safety of the complainant.[191]

It is difficult to extract a requirement that there be a pattern of non-disclosure from the elements of aggravated assault and its minimal definition of fault. It is here that the English experience with prosecutorial guidelines is instructive. Prosecutorial guidelines should rule out prosecuting cases like *DC*, where there is one isolated act of non-disclosure, followed by years of responsible sexual behaviour, and no transmission. Rather, prosecution should focus on cases like *Leone* or *Nduwayo*, where there is a clear pattern of reckless disregard for the potential harm to one or more complainants and a likelihood that such behaviour will persist without the intervention of criminal law.[192]

B. Certainty

Since *Cuerrier*, we have seen inconsistency in the case law, with different courts and juries giving different meaning to "significant risk." As predicted by Justice McLachlin in *Cuerrier*, the significant risk threshold has not been precise enough for consistent judicial application, and there is insufficient certainty to guide individual behaviour.

In the earlier cases, courts appeared to use the significant risk test to distinguish between protected and unprotected sex, but even this line was not drawn consistently.[193] *Mekonnen* sidestepped the entire issue and did not consider risk, convicting the accused of aggravated sexual assault, though condoms were used consistently.[194] Later cases continue to misapply the test. In *Mabior* and *DC*, [195] the trial judges equated significant risk with *any* risk.[196] While the-

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[190] *Supra* note 169. The maximum sentence for unlawfully causing bodily harm is 10 years (on indictment) and 18 months (on summary conviction). One of the difficulties with unlawfully causing bodily harm in this context is the requirement from *R v DeSousa* of an underlying unlawful act [1992] 2 SCR 944 [*DeSousa*].

[191] *Ibid*.

[192] As I have argued elsewhere, it is also essential that public health options be exhausted before there is resort to the criminal law (Grant, "The Boundaries of the Criminal Law", *supra* note 6).

[193] See e.g. *Edwards*, *supra* note 26.

[194] *Supra* note 34 at paras 9, 40, 52, 58.

[195] *DC* (CQ), *supra* note 28.

se cases have both been reversed on appeal, even the appellate judgments invite uncertainty:

> … no comprehensive statement can be made about the impact of low viral loads on the question of risk. Each case depends on the facts regarding the particular accused, and each case will depend on the state of the medical evidence at the time and the manner in which it is presented in that particular case.[197]

Recent cases have interpreted *Cuerrier* to mean that it is for the trier of fact to assess risk in each case, even where the intercourse was protected or where other circumstances rendered the risk extremely low. This has resulted in unpredictability in the application of the law and possible over-extension of *Cuerrier*. In *JT*, the British Columbia Court of Appeal rejected the argument that *Cuerrier* set a benchmark level of risk and held that risks must be assessed in each individual case, even where condoms were used or other circumstances rendered the risk below that posed by protected sex.[198] In *JAT*, the trial decision after *JT*, the judge sought a balanced approach:

> A significant risk means a risk that is of a magnitude great enough to be considered important. … There are two components to the proof of significant risk of harm. There must be significant risk, and the potential consequences must be serious bodily harm. … It is no longer the case that all people infected with the virus will eventually develop AIDS and die prematurely. This is important because the nature of the harm necessarily affects the threshold of significance required to establish deprivation. As the magnitude of the harm goes up, the threshold of probability that will be considered significant goes down.[199]

Aware of the uncertainty inherent in the *Cuerrier* test, the Manitoba Court of Appeal in *Mabior* suggested that the Supreme Court of Canada consider revisiting the law in this area:

> Again, with respect to viral loads, the ability to show that an accused had a common infection or an STD at the time of sex that might have led to a spike in the viral load may very well prove

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[196] *Mabior* (QB), *supra* note 37 at para 134. This error was pointed out by the Manitoba Court of Appeal: *Mabior* (CA) *supra* note 5 at paras 10, 19.

[197] *Mabior* (CA), *supra* note 5 at para 113 cited with approval in *DC* (CA), *supra* note 4 at para 113.

[198] *JT*, *supra* note 29.

[199] *JAT*, *supra* note 4 at paras 56, 77-78.

> elusive. In light of these concerns and the developments in the science, the Supreme Court may wish to consider revisiting the test in *Cuerrier* to provide all parties with more certainty.[200]

Since it is a matter for the trier of fact, judges may leave it to juries to decide whether or not the use of a condom negates the significant risk of bodily harm. Juries must, first, assess the risk of protected sex from expert evidence, which may vary somewhat from case to case; second, they must determine whether that risk is sufficiently serious to negate consent. This could lead to the problematic situation where protected sex is criminalized for one individual and not for another, or in one jurisdiction and not in another.

One of the justifications offered for the criminalization of non-disclosure of HIV status is that it deters non-disclosure and encourages persons who are HIV-positive to act responsibly in sexual activity.[201] But given the jurisprudence, it is impossible to advise someone who is HIV-positive as to their legal responsibility. While the simplest position would be to say one must always disclose, this does not appear to be the current state of the law. How would a lawyer or public health official answer questions such as: (i) "Do I need to disclose if I use a condom?"; (ii) "Can non-disclosure result in criminal liability if I have an undetectable viral load?"; or (iii) "What if the sexual activity we are engaging in is low risk?" The courts interpreting *Cuerrier* have not reached a consensus on these questions, and persons with HIV are left with uncertainty, thus undermining the deterrence rationale.[202]

C. Cuerrier *and Over-Criminalization*

Lower courts often adopt the test from *Cuerrier* without question. What tends to get lost from that decision is the Supreme Court's concern that criminalization be approached with caution, most clearly recognized by Justice McLachlin:

> The broad extensions of the law proposed by my colleagues may also have an adverse impact on the fight to reduce the spread of HIV and other serious sexually transmitted diseases. Public health workers argue that encouraging people to come forward for testing and treatment is the key to preventing the spread of HIV and similar diseases, and that broad criminal sanctions are

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[200] *Mabior* (CA), *supra* note 5 at para 152. The Québec Court of Appeal in *DC* echoed this request (*supra* note 4 at para 121).

[201] See Grant, "The Boundaries of the Criminal Law", *supra* note 6.

[202] Mykhalovskiy, Betteridge & McLay, *supra* note 103 at 11.

> unlikely to be effective. Criminalizing a broad range of HIV related conduct will only impair such efforts. Moreover, because homosexuals, intravenous drug users, sex trade workers, prisoners, and people with disabilities are those most at risk of contracting HIV, the burden of criminal sanctions will impact most heavily on members of these already marginalized groups. The material before the Court suggests that a blanket duty to disclose may drive those with the disease underground.[203]

Justice McLachlin's fears about the uneven application of the law to certain populations were prescient, although not all the groups she identified have been singled out thus far. A recent Ontario study has shed light on the demographics surrounding prosecutions for non-disclosure.[204] Not surprisingly, 91% of those charged in Canada for failing to disclose their HIV status are men. Seventy-two percent of the charges laid are for men not disclosing their status to women. Overall, 65% of all Canadians charged are men alleged to have not disclosed to female sexual partners, although the authors note that there has been a recent trend towards charging men who have sex with men.[205] At 38% of all accused, Caucasian men still form the majority of those charged. Thirty-three percent of the cases involved black accused. However, race cuts across different types of prosecutions. Black men account for almost 50% of heterosexual men who have been charged since 2004, while the majority of the same-sex cases involve Caucasian men.

Contrary to Justice McLachlin's expectations, gay and bisexual men appear to be under-represented in terms of accused persons, given the prevalence of HIV in those populations. The Ontario study's authors suggest that gay and bisexual populations may have a greater acceptance of HIV-related risks than do the women who accuse heterosexual sexual partners of non-disclosure. The authors further suggest that gay men "may also be less inclined than female complainants to understand themselves to have been 'victimized' or to proceed with complaints to the police in circumstances in which non-disclosure has occurred."[206] Some have argued that non-disclosure prosecutions have the potential to push gay men towards more casual sexual encounters where prosecution

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[203] *Cuerrier*, *supra* note 2 at para 55.

[204] Mykhalovskiy, Betteridge & McLay, *supra* note 103 at 43.

[205] *Ibid* at 11. See also Adam McDowell, *supra* note 104.

[206] Mykhalovskiy, Betteridge & McLay, *supra* note 103 at 43.

is less likely and disclosure is not expected by the parties involved.[207] Police officers and prosecutors may also take a different approach to laying charges when complaints are received from gay men as opposed to heterosexual women. Society may be more likely to see women as victims of predatory men, whereas gay men are more likely to be seen as complicit in the acquisition of the virus. The gendered basis of sexual assault in the HIV nondisclosure context is complicated because of the higher proportion of male complainants than in sexual assault generally and because of the potential for certain groups of women to be targeted for prosecution.

The authors of the Ontario study note that there has been a significant jump in the number of prosecutions since 2004. They describe the data as follows:

> While our data support the claim that cases are increasing over time, they do not indicate a gradual increase. Rather, they show a long period of relative inactivity, with only a few criminal cases per year (with the exception of 1999 the year following the *Cuerrier* decision), followed by a sharp increase in annual cases in 2004 that is sustained until 2009. Rather than a criminalization creep, the trend in criminal cases follows a two-phase process involving a long period of inactivity followed by a sustained increase.[208]

The authors identify 104 cases in which 98 accused persons were charged with criminal offences relating to non-disclosure. During the first 14 years for which data are available, the number of cases ranged from zero to six per year. In 2004, the number went up to nine and peaked in 2006 at 16. Approximately 65% of all criminal cases have occurred between 2004 and 2009.[209] Thus, while our ability to manage HIV has improved, and while our understanding of the risks involved with different types of sexual activity has grown, there has still been an increase in the rate of non-disclosure prosecutions. The study also points out that in at least 38% of all convictions across Canada, there is no allegation that HIV was transmitted. In 22% of the cases, transmission was alleged, and in 18% of the cases some complainants were infected while others were not. For the remaining 22% the authors were unable to determine wheth-

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[207] See e.g. Gary Marks, Scott Burris & Thomas A Peterman, "Reducing Sexual Transmission of HIV From Those who Know They are Infected: The Need for Personal and Collective Responsibility" (1999) 13:3 AIDS 297.

[208] Mykhalovskiy, Betteridge & McLay, *supra* note 103 at 13.

[209] *Ibid* at 44.

er transmission took place.[210] It is likely that the unknown category includes both cases of transmission and non-transmission, suggesting that in more than 40% of the cases, no bodily harm was done to the complainant. At the same time, there is an emerging body of social science evidence that suggests that the criminalization of non-disclosure does not necessarily shape the behaviour of those who are HIV-positive.[211]

In *Cuerrier*, Justice Cory wrote about the importance of protecting people from "high-risk" sexual behaviours.[212] Couple this with his statement that protected sex would probably not create a significantly serious risk, and one sees that the Court did not intend to criminalize all risk. The trial judge in *JAT* recognized that *Cuerrier* did not intend to criminalize every exposure, and she pointed out the impact of scientific advances in HIV medication on the decision in *Cuerrier*. She was not satisfied "that a [12 in 10,000] risk of transmission of the virus that, while still a serious lifelong harm, is now largely treatable, constitutes endangerment to life. It follows that the Crown had not proved aggravated sexual assault."[213] She based her decision, in part, on recent advances in treatment for HIV using antiretroviral medications:

> HIV is no longer synonymous with AIDS and premature death. According to Dr. Murphy, those living with HIV who receive treatment have a normal life expectancy. These projections are necessarily based on extrapolation because antiretroviral drugs have only been available since 1987. Dr. Murphy was confident, however, that this is a realistic projection given that the drugs used to treat HIV have become increasingly less toxic and more targeted since their development 23 years ago.[214]

The trial judge concluded by noting that the accused's conduct was reprehensible but not criminal, echoing the exhortation from *Cuerrier* to approach criminalization cautiously:

> I should not be taken to condone the behaviour of the accused. He had a moral obligation to disclose his HIV-positive status to

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[210] *Ibid* at 44.

[211] See e.g. Scott Burris et al, "Do Criminal Laws Influence HIV Risk Behavior? An Empirical Trial" (2007) 39 Ariz St LJ 467.

[212] *Cuerrier*, *supra* note 2 at para 141.

[213] *JAT*, *supra* note 4 at para 58.

[214] *Ibid* at para 22. The extended life expectancy of HIV-positive persons was also recognized in *Wright*, *supra* note 4 at para 9, but was not applied to remove culpability in that case.

> his partner and to give the complainant the opportunity to assume or reject the risk involved in sexual activity with the accused, no matter how small. But not every immoral or reprehensible act engages the heavy hand of the criminal law. Aggravated sexual assault is a most serious offence–a person convicted of this charge is liable to imprisonment for life, the harshest penalty provided for in law. Only behaviour that puts a complainant at significant risk of serious bodily harm will suffice to turn what would otherwise be a consensual activity into an aggravated sexual assault. In my view, a risk of transmission of HIV of 0.12% falls short of that standard.[215]

While the appellate decisions in *Mabior* and *DC*–and the trial judgment in *JAT*–demonstrate a positive trend towards a more cautious approach to criminalization, the significant risk of serious bodily harm test still allows for unpredictability and inconsistency.

V. Future Directions

It is time to rethink *Cuerrier*. A serious consequence crime is not appropriate where the virus is not transmitted. The experience of England and Wales, Australia, and New Zealand offer at least two options for consideration in Canada. First, we could adopt the English position (also followed in six Australian jurisdictions) where prosecutions are undertaken only if the virus has been transmitted. In England and Wales, for example, exposure without transmission is criminalized only where there is an actual intent to transmit the virus and there have been no such cases to date. Such an approach would remove the difficulty that surrounds issues of condom use and viral load, shifting the focus from risk to actual harm. There has never been a prosecution in Canada where the virus was transmitted despite condom use or in the context of an undetectable viral load. Only prosecuting cases involving transmission would be a major departure from the *Cuerrier* approach in Canada, but it could cut our rate of prosecution by as much as 40%. The concern with this approach is that it may not capture those who repeatedly expose their partners to risk without disclosure, but who have, fortuitously, not transmitted the virus.

This is why the second approach, used in New Zealand and two Australian states, is more appropriate for Canada. The New Zealand approach recognizes that causing serious harm to an individual warrants a more serious offence than cases in which no harm is caused. Where no transmission has occurred, a less serious offence, such as simple (sexual) assault or common nuisance is more appropriate than aggravated (sexual) assault. Common nuisance was some-

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[215] *JAT*, *ibid* at para 89.

times utilized in pre-*Cuerrier* prosecutions.[216] Common nuisance in section 180 of the *Criminal Code*, with a maximum sentence of two years, is a close match to the New Zealand nuisance offence.[217] Conviction for common nuisance would not label the individual a sex offender and would reflect the approach taken in other jurisdictions examined in this paper that treat non-disclosure as an offence related to bodily harm rather than to sexual assault. In New Zealand, the practice of charging a less serious offence with a maximum sentence of one year where transmission does not occur, and the explicit provision that reasonable safeguards will negate liability, provide for a cautious and more nuanced approach to criminalization than the blanket application of aggravated assault or aggravated sexual assault that occurs in Canada.

Under Canadian law it is acceptable to convict persons who cause more severe harm of a more serious offence, even if they have the same mental state as those who do not cause harm. Gradations of offences would acknowledge that the transmission of HIV to the complainant matters. The Supreme Court of Canada has acknowledged the legitimacy of punishing offences with the same level of fault more seriously if they lead to a particular harm:

> Conduct may fortuitously result in more or less serious consequences depending on the circumstances in which the consequences arise. The same act of assault may injure one person but not another. The implicit rationale of the law in this area is that it is acceptable to distinguish between criminal responsibility for equally reprehensible acts on the basis of the harm that is actually caused. This is reflected in the creation of higher maximum penalties for offences with more serious consequences. Courts and legislators acknowledge the harm actually caused by concluding that in otherwise equal cases a more serious consequence will dictate a more serious response.[218]

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[216] In fact, common nuisance was the first charge ever laid in a Canadian non-disclosure case where transmission occurred. See *R v Summer*, (1989) 98 AR 191, AJ No 784 (QL) (Alta Prov Ct), aff'd 68 Alta LR (2d) 303, 99 AR 29, 73 CR (3d) 32, [1989] AJ No 820 (CA) (two of the complainants tested positive for HIV and Summer was sentenced to 1 year of imprisonment).

[217] In cases with multiple counts, sentences would likely be made consecutive thus creating the potential for sentences longer than two years.

[218] *DeSousa* supra note 190 at 966-967.

Recognizing the additional harm to the complainant where the virus is transmitted may warrant an aggravated assault charge.[219] In my view, we should limit liability for such a serious offence to cases where it can be proven that the accused transmitted the virus to the complainant. While it is true that this position requires causation to be proved the Crown should have a heavy burden in proving this very serious charge.

Furthermore, it is questionable whether all cases of non-disclosure should give rise to criminal liability. Prosecutors need to be cautious in their exercise of discretion before laying charges for isolated acts of non-disclosure where no transmission occurs. The English prosecutorial guidelines are instructive here. They provide that the level of fault or recklessness required will only be met where there is an ongoing course of non-disclosure. Similarly, where reasonable precautions are taken, criminal charges are not appropriate: reasonably careful use of a condom should preclude prosecution. It may be necessary to clarify what careful condom use includes, as the Manitoba Court of Appeal in *Mabior* has begun to do. That Court, for example, stated that where a condom breaks or falls off it is the same as if no condom were used and immediate disclosure is required.[220] Similarly, it is arguable that where tests indicate that the accused's viral load was undetectable and the virus was not transmitted, criminal prosecution is not appropriate.

The changes proposed here would require either legislative action, which seems unlikely, or a reconsideration of *Cuerrier* by the Supreme Court of Canada. With the changing picture of HIV/AIDS in Canada and increased understanding of transmission risks, *Mabior* and *DC* provide the Supreme Court with an excellent opportunity to begin this process.

Conclusion

It is important to bear in mind that every accused person in these cases is a member of a highly stigmatized and disadvantaged group in Canadian society. This is not intended to justify non-disclosure but rather to suggest that criminalization must be approached with great caution because of the danger of further marginalizing persons with HIV.

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[219] As stated above, I believe a nonsexual offence like unlawfully causing bodily harm, or even aggravated assault, better reflects the nature of the harm where the virus is transmitted than aggravated sexual assault.

[220] *Mabior* (CA) *supra* note 5 at para 97. Compare "Toronto woman gets house arrest for failing to disclose HIV status to man" *Canadian Press* (20 November 2009) (Robin Lee St Clair disclosed her status immediately after a condom broke during sex, and pled guilty to sexual assault).

The current law is not functional. The *Cuerrier* test does not help to draw manageable lines regarding who should be subject to criminal liability and who should not. It does not provide a clear standard that leads to predictable results, and the approach to endangerment has resulted in a trend towards over-criminalization of individuals who do not transmit the virus. The law should encourage behaviour that reduces the risk of HIV transmission, such as the use of condoms and low-risk sexual practices. Over-reliance on disclosure shifts the focus away from the consequences that we are trying to avoid. It also assumes that the accused knows his or her HIV status and that his or her sexual partner will withhold consent once disclosure takes place. The consistent use of condoms and maintenance of an undetectable viral load are more effective means of curbing sexual transmission than relying on disclosure and a subsequent denial of consent. The law in Canada must both support effective public health messages by encouraging risk-reducing behaviour and recognize the actual harm caused by transmission of HIV by reserving the most serious offences for cases where the most severe harm has been caused.

Canada has taken an extremely harsh approach to prosecuting non-disclosure of HIV-positive status. No distinction is made between cases in which the virus is transmitted and those in which it is not. It is time to rethink this blanket approach. While both the approach taken in England and Wales (of only prosecuting cases where transmission results), and that of New Zealand (where a much less serious offence is charged if no transmission results) are preferable to the Canadian approach, I would argue that the New Zealand approach is most suitable for Canada. Aggravated assault offences should be reserved for cases where the virus has been transmitted. Where there is a pattern of non-disclosure, and no transmission, less serious criminal offences are more appropriate. The Canadian approach to date–uncertain, inconsistent, and out of step with other Commonwealth jurisdictions–cries out for reconsideration.

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CRIMINALIZATION OF THE INTENDED TRANSMISSION OR KNOWING NON-DISCLOSURE OF HIV IN CANADA

Matthew Cornett *

The author of this article argues for a continuation of Canada's approach to criminalization of the intentional transmission or knowing non-disclosure of HIV, while suggesting certain reforms. The article begins by exploring the epidemiological aspects of HIV, competing theoretical models of sexual responsibility, and the distinctive challenges of applying criminal law in the sexual realm. Next the author presents and refutes anti-criminalization arguments based on public health concerns, stigmatization, and the emergence of HAART therapy. The article focuses on knowing non-disclosure, and proposes retaining the test for fraud set out in *R v Cuerrier*, while harmonizing its application with scientific evidence regarding transmission risk and modern sexual health guidelines; these factors are to guide judges, juries, and crown prosecutors in dealing with each offence. The article concludes by discussing areas of divergent interpretation in the current law: the definition of fraud adopted in *Cuerrier* and what constitutes "serious risk," and "significant harm." On this basis, the author critiques the recent application of *Cuerrier* in *R v Mabior* and *R v JAT*.

L'auteur défend ici l'approche canadienne de criminalisation de la transmission du VIH, intentionnelle ou selon la connaissance d'une non-divulgation, tout en suggérant certaines réformes. L'article débute par une exploration des aspects épidémiologiques du VIH, des modèles théoriques concurrents de la responsabilité sexuelle et des défis d'application du droit criminel aux affaires de nature sexuelle. Ensuite, l'auteur présente et réfute les arguments contre la criminalisation fondés sur des préoccupations de santé publique, de stigmatisation et d'émergence du traitement antirétroviral hautement actif (TAHA). L'article s'attarde sur la connaissance d'une non-divulgation et propose de retenir le test pour la fraude établi dans *R c Cuerrier* tout en harmonisant son application aux données scientifiques disponibles sur le risque de transmission et les indicateurs modernes de santé sexuelle. Ces facteurs devraient guider les juges, jurys et procureurs de la Couronne dans leur travail pour ce type d'infraction. L'article conclut en discutant des sphères où les interprétations du droit courant divergent : la définition de la fraude adoptée dans *Cuerrier* et ce qui constitue un « risque grave » et une « lésion grave ». Sur ces bases, l'auteur critique les récentes applications de *Cuerrier* dans *R v Mahior* et *R v JAT*.

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Introduction

Since the Supreme Court's seminal 1998 judgment in *R v Cuerrier*[1], 63 people in Canada have been criminally charged for not disclosing their HIV-positive status, including 32 from January 2006 to the beginning of 2009.[2] These prosecutions include the well-known case of *R v Aziga*, which resulted in multiple convictions for first-degree murder.[3] Nearly a dozen years after *Cuerrier*, this paper will re-examine and affirm the wisdom of criminalizing the knowing transmission or non-disclosure of HIV in the sexual context. The first Part will attempt to contextualize the decision to criminalize HIV with respect to its sociological backdrop and how one might understand "responsibility" in the sexual realm. The second Part lays out the emerging challenge by activists and academics to the *status quo* of criminalization, ultimately the motivating factor behind this work. The third Part focuses on objectives internal to criminal law and concludes that criminalization in the context of sexual transmission of HIV cannot be excluded prima facie as a valid public policy response, even in light of broader public health objectives. The fourth and final Part addresses the judgment in *Cuerrier* and suggests that the test for fraud laid out by the majority can be tailored to ensure that the criminal law is applied appropriately in circumstances that accord with both our understandings of responsibility in the sexual realm and modern public health objectives. Several of the most recent court rulings in the field are critiqued according to these guidelines, and suggestions are made for future judicial interpretation in the area of sexual HIV non-disclosure.

I. Context: the HIV/AIDS Epidemic in Canada

It is necessary to first consider the social context of any behaviour to decide whether it should be targeted for the application of the criminal law. There are many actions one might consider morally "wrong" or socially undesirable, but which are not criminalized due to Canadian social norms or the difficulty of policing them (e.g. adultery and suicide). Furthermore, beyond helping us code certain conduct "criminal," the social context of behaviour also

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[1] [1998] 2 SCR 371, 127 CCC (3d) 1 [*Cuerrier*].

[2] See André Picard, "U.S., Canada Lead World in Prosecuting Those who Transmit AIDS Virus" The Globe and Mail (21 July 2010) A12; Alison Symington, "Criminalization Confusion and Concerns: The Decade Since the *Cuerrier* Decision" (2009) 14:1 HIV/AIDS Policy and Law Review at 5.

[3] See e.g. 2010 ONSC 3683, [2010] OJ No 2763; 164 CRR (2d) 122, 75 WCB (2d) 673, [2007] OJ No 4965 (various applications by Aziga exist, but, as Aziga opted for trial by jury, there is no "judgment").

helps determine the severity of fines or sentencing, as well as the gradation of possible charges. For example, both assault and sexual assault require the application of force without consent, but the latter occurs in the context of a sexual act and carries a significantly heavier maximum sentence. This Part examines the epidemiology of HIV in Canada, several theoretical models of sexual health and responsibility, and factors that militate for or against attributing moral blame in a sexual context.

A. The Epidemiology of HIV

HIV/AIDS is a matter of increasing public concern that merits strong intervention. More Canadians are now living with HIV–an estimated 65,000 at the end of 2008, compared with 57,000 at the end of 2005.[4] Though this number might reflect the increased lifespan of infected persons due to the introduction of highly active antiretroviral therapy ("HAART"), the number of new infections also continues to increase–between 2,300 and 4,500 new infections occurred in 2005, compared with 2,100 to 4,000 in 2002.[5] Estimates place Canada's adult prevalence rate (i.e. the percentage of the adult population aged 18-49 living with HIV/AIDS) at 0.3%, meaning 30 out of 10,000 adults are infected.[6]

However, the means we choose to reduce the number of HIV infections, and the trade-offs between the techniques employed will be shaped by fact. For example, of the HIV-positive individuals listed above, it is estimated that 27% are unaware of their status.[7] Given that this category accounts for the majority of transmissions,[8] varying policy responses might be selected to encourage testing and disclosure.

It is important to note that while HIV can and does infect individuals indiscriminately, its effects have not been experienced in a socially-proportionate manner. In Canada, men who have sex with men, ("MSM") though accounting for a decreasing proportion of recent infections, nonetheless

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[4] Public Health Agency of Canada, *National HIV Prevalence and Incidence Estimates in Canada for 2008* (Ottawa: PHAC, 2010) at 2.

[5] Public Health Agency of Canada, *HIV/AIDS Updates, November 2007* (Ottawa: PHAC, 2007) at 10 [*PHAC Updates*].

[6] CIA World Factbook, *Country Comparison: HIV/AIDS Adult Prevalence Rate*, online: CIA World Factbook <www.cia.gov/library/publications/the-world-factbook/rankorder/2155rank.html> [CIA World Factbook].

[7] *PHAC Updates*, *supra* note 5 at 10.

[8] *Ibid*.

represent 76.1% of cumulative reported AIDS cases and 68.1% of positive HIV test reports among adult males since testing began in 1985. Even starker are figures from studies listing HIV prevalence rates among MSM in large urban centres: 12.7% in Toronto, 12.4% in , and over 11% in Vancouver.[9] An increasing proportion of those with HIV-positive test results in Canada are women: 27.8% as of 2006. Individuals from HIV-endemic countries, Aboriginal peoples, and injection drug users are overrepresented in Canada's HIV/AIDS population.[10] Offenders in Canadian correctional facilities also experience a higher HIV prevalence (2%) due to patterns of drug use and high-risk sexual practices that may resume or continue after incarceration.[11]

For the purposes of this paper, several other facts are also relevant. First, in many countries, adult HIV prevalence rates are astoundingly high and caution against direct comparisons with the Canadian situation: Swaziland (26.10%), Botswana (23.9%), and Lesotho (23.20%) are among the direst examples.[12] Second, HIV-1 comprises many sub-types (A; B, predominant in Canada at 92.5% of infections; C; D; and recombinant), each of which evidences different primary- or multi-drug resistance to antiretrovirals, creating the possibility of cross-infection.[13] Finally, a national study found that 50-60% of grade 9 and 11 students believe there is a vaccine available to prevent HIV infection, and that 36% of grade 11 students believe there is a cure.[14] Prevalence rates, the possibility of cross-infection among HIV-positive individuals, and levels of sexual education will affect not only individual behaviour, but also any societal choice to criminalize sexual non-disclosure.

B. Theoretical Models of Responsibility for Sexual Health

Criminalizing the intended transmission or knowing non-disclosure of HIV, or another sexually-transmitted infection ("STI"), is a decision by the state to place a large portion of responsibility for sexual health on the diag-

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[9] *Ibid* at 61.

[10] *Ibid* at 47.

[11] *Ibid* at 119.

[12] CIA World Factbook, *supra* note 6 (all rates refer to 2007 figures).

[13] Public Health Agency of Canada, *HIV-1 Strain Surveillance in Canada*, online: Public Health Agency of Canada, <www.phac-aspc.gc.ca/publicat/epiu-aepi/epi_update_may_04/14-eng.php> (even if an HIV-positive person's condition is under control due to HAART therapy, that person could acquire a new, and now untreated, strain of HIV).

[14] *PHAC Updates*, *supra* note 5 at 19.

nosed individual. In fact, most crimes, such as theft or murder, require examining only the accused's agency in bringing about a harmful result; the victim's actions are largely or totally irrelevant to the initial decision to criminalize the behaviour and are implicated only in a limited way when considering excuses or defences in law, such as provocation or self-defence. Crimes of inadvertence, such as criminal negligence, also rarely require an examination of victim conduct. The injured party is subjected to harm that he has no interest in, and over which he cannot truly exercise control. Even popular discourse regarding rape (now renamed "sexual assault") largely considers victim behaviour and sexual history as irrelevant to a determination of the accused's wrongdoing. This is arguably not true in cases involving STIs. Depending on the theoretical model to which one subscribes, criminalization may reinforce the moral status quo, or constitute a situation-specific shift in accountability and blameworthiness to the HIV-diagnosed partner. How we, as individuals or as a society, conceive of this duty of healthy sexual behaviour and its strength will determine the model of choice.

The first model places responsibility for sexual health entirely on the diagnosed individual, who has deviated from the "normative" expectation of health. Because the diagnosed individual has the most complete information with respect to his condition and its potentially serious effects if transmitted, it is he who bears the ultimate burden of disclosure and of taking adequate measures to protect his partners.

The second model, which could be termed "libertarian," holds that everyone is responsible for their own health, regardless of their partner's knowledge or health status. If an individual does not wish to risk acquiring an STI, he should use adequate protection, ask appropriate questions and demand proof of health, or abstain from sexual activity entirely. As a result, if a person engages in consensual sex, protected or unprotected, he must bear the burden of its risk and any social or medical consequences. Though often described as "shared responsibility," it is this model of individual responsibility that public health campaigns have sought to establish and reinforce through social norms.

A third model emphasizes the social aspects of individual choice and the need to take collective responsibility for attitudes and behaviours that may promote infection.[15] This could also be termed the "societal" or "no-fault" model. It recognizes that powerful environmental factors including norms, economic conditions, and laws shape risk-taking choices and are "inputs" into

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[15] Gary Marks, Scott Burris & Thomas A Peterman, "Reducing Sexual Transmission of HIV From Those Who Know They are Infected: The need for Personal and Collective Responsibility" (1999) 13:3 AIDS 297 at 301.

the cognitive process of individuals. Examples might include sexual cultures that encourage multiple partners and unprotected sex or laws that discourage long-term, stable relationships among gay men. In the past, public health programs have focused on altering community practices with regard to many health threats, including smoking, caloric intake, and binge drinking. Similar approaches have been used in an attempt to control HIV, such as the establishment of privacy and anti-discrimination laws that encourage HIV testing, or efforts to change norms of sexual behaviour in gay bars.[16] This model, taken to its extreme, operates on the premise that asking for personal responsibility on the part of either partner in the absence of these measures is to blame a helpless victim.

The key to understanding the overall responsibility for the spread of STIs in Canada is likely a blend of these models, comprehending both the diagnosed individual and putative "victim" as relevant actors, but at present placing liability on the former. However, it is conceivable that this society-wide choice of attributing criminal responsibility to one partner or the other might poorly fit specific factual circumstances or cultural factors. For example, as mentioned above, MSM experience a far higher HIV prevalence rate than other communities and make up a large majority of documented AIDS cases.[17] In addition, many MSM remember (or have learned about) the AIDS crisis of the 1980s, and they have long been the target of HIV-control and sexual education campaigns.[18] In this context, the gap between what we might expect of the infected individual and "victim" is not so great as it might be in the heterosexual community, and a gay male who chooses to have unprotected sex with a partner of unknown status could be said to be behaving just as recklessly as his non-disclosing partner. This logic was considered in *R v Edwards* and rejected as being not only antithetical to criminal law, but also contrary to the realities of sexual behaviour (discussed in the next Part):

> It is clear that Mr. X did not inquire of Mr. Edwards nor did Mr. Edwards inquire of Mr. X whether the other was infected with any disease and in particular, if the other was HIV positive. While it is easy to suggest that such an inquiry would be particularly wise and very much appropriate in the gay community when anal sexual intercourse is anticipated, *there is no such*

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[16] *Ibid* at 302.

[17] *PHAC Updates*, *supra* note 5 at 61.

[18] Allie Lehman, "Safer Sex & Young Gay and Bisexual Men: A Focus Group Report", online: AIDS Committee of Toronto <www.actoronto.org/research.nsf/pages/focus+group+report>.

> *standard in law, and human nature and circumstances, alcohol, passion, etcetera, dictate against such a standard*.[19]

C. Particularities and Challenges of the Sexual Realm

There are many examples in which the public, private, or particular nature of an act has been of interest to the law, and has influenced whether and to what degree criminal law sanctions are invoked. These include the decriminalization of consensual "homosexual acts" (exemplified by then-Justice Minister Pierre Trudeau's famous statement that "[t]here's no place for the state in the bedrooms of the nation"), assaults permitted in sport, and the split between assault and sexual assault. However, the question of whether, or to what degree, behaviours should be criminalized must account not only for the setting in which they take place, but also the practical difficulties of enforcement or conforming one's behaviour to the ideal. For example, projects including the creation of Insite (North America's first legal, supervised drug injection site) in Vancouver's Downtown Eastside neighbourhood,[20] or Portugal's 2001 decision to decriminalize personal possession of drugs (including marijuana, cocaine, heroin, and methamphetamines), seem to acknowledge the quasi-voluntary nature of drug use, its overwhelming addictive qualities, and the need for treatment.[21]

As suggested by the above quote from *R v Edwards*, the sexual realm presents similar challenges that militate both for and against assigning criminal responsibility to diagnosed individuals. Sex is inherently bound up with emotion, physical desire, and disinhibition. In her concurring opinion in *Cuerrier*, Justice McLachlan (as she then was) stated that "[p]eople can and do cast caution to the winds in sexual situations,"[22] while Justice Cory, for the majority, added:

> It cannot be forgotten that the act of intercourse is usually far more than the mere manifestation of the drive to reproduce. It can be the culminating demonstration of love, admiration and respect. It is the most intimate of physical relations and *what ac-*

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[19] *R v Edwards*, 2001 NSSC 80, 194 NSR (2d) 107 at para 18 [*Edwards*] [emphasis added].

[20] Vancouver Coastal Health, "Insite - Supervised Injection Site", online: Vancouver Coastal Health <supervisedinjection.vch.ca>.

[21] Maia Szalavitz, "Drugs in Portugal: Did Decriminalization Work?" (26 April 2009), online: Time Health and Science <www.time.com/time/health/article/0,8599,1893946,00.html>.

[22] *Cuerrier*, *supra* note 1 at para 49.

> *tions and reactions led to mutual consent to undertake it will in retrospect be complex*.[23]

Thus, the largely private negotiations that occur prior to sexual relations are often intermixed with feelings of lust, or those of love and admiration, or a mixture of all three. These emotions contribute to a discourse between partners that is not ideal for candid discussions of sexual health status. As well, some sexual acts are performed in the context of alcohol or drug use, which can impair proper judgment; they may also be negotiated in environments which implicitly discourage verbal communication between partners, such as bathhouses or loud nightclubs.

Finally, bargaining positions are rarely equal. Power dynamics that flow through society related to physical strength, gender, race, and economic advantage are reflected in an individual's micro-choices, often relating to how he perceives his own attractiveness vis-à-vis that of his partner. For example, one study has shown that girls who perceive themselves as less attractive or less self-efficacious are less likely to use a condom with their partners.[24] Similar beliefs are held with respect to race and status in the gay community, which is thought to privilege a white, upper-middle class aesthetic, and contribute to inequalities of power.[25] HIV-positive individuals may also have concerns over the potential repercussions of disclosure, including fears that all prospective partners will reject them sexually or emotionally.

The sexual realm reveals many barriers to rational and complete communication. However, most of these challenges affect the parties to a sexual act equally. That is, the diagnosed individual is confronted with the same difficulties in disclosing his status or ensuring condom use as is the "victim" in protecting his own sexual health. Thus, context does not contribute conclusively to the selection of a model attributing responsibility entirely to the diagnosed individual or to his partner. Instead, since rational behaviour in the sexual realm is often contingent on numerous factors, this alters how, or whether, we decide to criminalize the knowing transmission or non-disclosure of HIV. In an area of inherent uncertainty, it might also be the *goal* of the criminal law to definitively attribute the protective duty to one party. Physical and emotional

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[23] *Ibid* at para 126 [emphasis added].

[24] Jean Tschann et al, "Relative Power Between Sexual Partners and Condom Use Among Adolescents" (2002) 31 Journal of Adolescent Health 1.

[25] Adam Isaiah Green, "Health and Sexual Status in an Urban Gay Enclave: An Application of the Stress Process Model" (2008) 49:4 Journal of Health and Social Behavior 436.

vulnerabilities naturally exist when performing sexual acts. Bodily penetration and physical intimacy necessitate trust and reliance, even when precautions have been taken. Applying the criminal law can clarify who will be blamed if this trust is abused.

These issues must be considered when addressing the questions raised in the Parts below: should an individual's knowledge of his HIV-positive status decisively tip what is set out above as a *balance* of responsibility among partners towards the diagnosed individual, and is criminal law the appropriate mechanism for regulating such a complex array of situations?

II. The Challenge to Criminalization of Non-Disclosure

Though criminalization of the intended transmission or knowing non-disclosure of HIV has been well-established by two rulings of the Supreme Court of Canada (*Cuerrier* and *R v Williams*[26]), the past few years have been marked by challenges to this status quo. These challenges to criminalization have come in the form of increased activism by criminalization opponents in both the popular media and academic discourse. Examples of the former include several recent newspaper articles and editorials,[27] some of which have elicited more neutral or pro-criminalization replies.[28] A large majority of law and policy documents produced recently by academics have taken an anti-criminalization stance;[29] Justice Edwin Cameron, a judge of the Constitutional Court of South Africa and scholar in the field, has produced many of these re-

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[26] *R v Williams*, 2003 SCC 41, [2003] 2 SCR 134, 176 CCC (3d) 449.

[27] See André Picard, "Prevent and Treat HIV, Don't Criminalize It", *The Globe and Mail* (14 August 2008); Tracey Tyler, "Judge Slams Criminalization of HIV", *Toronto Star* (12 June 2009); Edwin Cameron, Michael Clayton, and Scott Burris, "A Tragedy, Not a Crime", *The New York Times* (7 August 2008); Mark A Wainberg,"Criminalizing HIV Transmission may be a Mistake" (2009) 180:6 Canadian Medical Association Journal 688.

[28] Picard, *supra* note 2; "AIDS and the Duty to Not Infect", Editorial, *The Globe and Mail* (21 July 2010); Philip B Berger, "Prosecuting for Knowingly Transmitting HIV is Warranted" (2009) 180:13 Canadian Medical Association Journal 1368.

[29] Symington, *supra* note 2; Carol L Gattely & Steven D Pinkerton, "Conflicting Messages: How Criminal HIV Disclosure Laws Undermine Public Health Efforts to Control the Spread of HIV" (2006) 10 AIDS and Behaviour 451; Ralf Jügens et al, *10 Reasons to Oppose Criminalization of HIV Exposure or Transmission* (2008), online: Open Society Institute <www.soros.org/initiatives/health/focus/law/articles_publications/publications/10reasons_20080918>.

ports and has been one of the most vocal proponents of global decriminalization.[30]

At this point, it is worth summarizing the principle arguments of decriminalization advocates, arguments which have in common the idea that criminal sanctions for non-disclosure of STIs undermine public health efforts to control the spread of HIV:

1. *The criminal law is not an effective tool for reducing the spread of HIV:* The sexual behaviours targeted by HIV-disclosure provisions are not easily deterred or altered due to many of the emotional factors referred to above. In addition, the incapacitative effect of the criminal law is experienced by very few offenders, and is therefore limited at best.

2. *Criminal laws create a disclosure-based norm for promoting safety in sexual interactions and thereby undermine the public health emphasis on personal responsibility for sexual health:* This "bipartite norm" places the HIV-diagnosed partner's responsibility to disclose before the other individuals' responsibility to protect themselves. It therefore encourages those at-risk to rely on prospective sex partners to disclose their HIV status and assume that there is minimal risk absent this disclosure, creating a false sense of security. In light of the large number of people who are unaware that they are HIV-positive, and given that the majority of new infections involve this category of persons, the message that any person could carry HIV, and that protection should always be used, is essential. Thus, criminalization fails to complement public health messaging and efforts to promote presumptive condom use.

3. *Criminal prosecutions for non-disclosure promote HIV-related stigma:* The history of HIV has been one of discrimination and stigmatization. This presents a great barrier to HIV-prevention efforts

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[30] See generally Scott Burris & Edward Cameron, "The Case Against Criminalization of HIV Transmission" (2008) 300:5 Journal of the American Medical Association 578; Edwin Cameron, Scott Burris & Michael Clayton, "HIV is a Virus, Not a Crime: Ten Reasons Against Criminal Statutes and Criminal Prosecutions" (2008) 11:7 Journal of the International AIDS Society; Edwin Cameron, Edwin "Criminalization of HIV Transmission: Poor Public Health Policy" (2009) 14:2 HIV/AIDS Policy & Law Review 1 [Cameron, *Criminalization*].

that revolve around voluntary compliance with public health recommendations to be tested, avoid risky behaviours, and seek treatment. Treatment has become of even greater importance as HAART is believed to reduce the risk of HIV transmission significantly, acting at once as a treatment and preventative measure.[31] Yet HIV disclosure laws punish HIV-diagnosed persons for engaging in consensual sexual activities and thus distinguish between persons with HIV and uninfected individuals. This reinforces an "us versus them" dichotomy, associates infection with criminality, and emphasizes that the trait is undesirable and dangerous. This creates an environment where the HIV-positive hide their diagnoses, and may result in an unwillingness to seek support services for fear of a loss of confidentiality, disincentives to test and definitively know one's status, and a reduction in the benefits that early medical care provides, such as a lower viral load and reduced infectiousness.

4. *Criminalization results in overzealous prosecution and the spread of misinformation about HIV-related risks:* The charges applied in cases of non-disclosure of HIV have varied considerably and, in at least two cases, the police have laid attempted murder charges based solely on an allegation of non-disclosure before unprotected sex.[32] This gives rise to what might be called the "creep of criminalization": escalating charges by police against HIV-positive persons. Charges have been laid for engaging in low-risk behaviours, such as oral sex or spitting at a police officer,[33] and this tendency to prosecute can lead to misinformation among the public, press, and judiciary about the risks of HIV-transmission, feeding back into the stigma surrounding the virus.

5. *The criminalization of non-disclosure of HIV in Canada is fraught with legal uncertainties:* The judgment in *Cuerrier* establishes two requirements for non-disclosure to amount to fraud: dishones-

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[31] Julio SG Montaner et al, "Association of Highly Active Antiretroviral Coverage, Population Viral Load, and Yearly New HIV Diagnoses in British Columbia, Canada: A Population-based Study" (2010) 376:9740 The Lancet 532.

[32] Cameron, *Criminalization*, *supra* note 30 at 65.

[33] James Turner, "HIV-positive Man on Trial for Assaulting Officer" *CBC News* (28 March 2011), online: <www.cbc.ca/news/canada/manitoba/story/2011/03/28/man-hiv-assault-police-trial.html>.

> ty and deprivation.[34] The latter requirement is satisfied by a "significant risk of serious bodily harm."[35] Disclosure is thus not made a blanket obligation, but it remains unclear where the line is to be drawn between activities that require disclosure and those that do not. This is especially the case with respect to lower-risk practices and undetectable viral loads. In addition to the uncertainty inherent in the test, since the judgment in *Cuerrier*, considerable advances have been made in understanding HIV transmission and treatment. This challenges the ability of courts to keep pace with medical advances and apply their understanding of modern treatments to the diverse circumstances of real-life sexual encounters.

These points can be roughly categorized into two groups, as they will be dealt with in this paper: (i) those that oppose the criminalization of HIV transmission or exposure *qua* criminalization;[36] and (ii) those that object to *how* the criminal law has been interpreted and applied, particularly in light of advances in the treatment of HIV/AIDS, and better (but still inconclusive) information about the risk of HIV transmission associated with various activities.[37]

III. Application of the Criminal Law

Having examined some of the contextual factors that must inform any debate over whether and to what extent to attribute responsibility for STI transmission, this Part addresses how the problem of non-disclosure fits within the operation of the criminal law. First, this Part will turn to the reasoning of the Supreme Court in *Cuerrier*, the most significant non-disclosure ruling to date. Second, it will examine how criminalization of the intended transmission or knowing non-disclosure of HIV might fulfill the traditional purposes of the criminal law vis-à-vis contrary arguments from a public health perspective. Third, it will discuss stigma and how one might conceive of the harm and moral blameworthiness of these behaviours. Finally, this Part will analyze how provisions relating to knowing transmission or non-disclosure should be crafted in Canada in order to avoid charges of HIV exceptionalism and to maintain fairness in the application of the criminal law.

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[34] *Cuerrier*, *supra* note 1 at paras 112-116.

[35] *Ibid* at para 128.

[36] See Part III – Application of the Criminal Law, *infra*.

[37] See Part IV – Judicial Interpretation: The Thresholds of Risk and Harm, *infra*.

A. Criminal Law as Applied to Non-Disclosure in R v Cuerrier

In *Cuerrier*, the Supreme Court unanimously ruled that HIV-positive individuals may be subject to criminal sanctions if they do not disclose their status before engaging in unprotected sex. The importance of this case merits a brief review of the facts. In August 1992, a public health nurse told Cuerrier that he was HIV-positive. Cuerrier was instructed to use condoms during sex and inform his partners of his status. Three weeks later, he began a relationship with one of the complainants, KM, and their relationship involved frequent acts of unprotected vaginal sex. Near the beginning of their relationship, KM discussed STIs with Cuerrier but did not ask specifically about HIV. Cuerrier told her that he had tested HIV-negative eight or nine months earlier, but did not mention his recent positive result. A few months later, they both had HIV antibody tests; Cuerrier tested positive, while KM tested negative and was told she might need further tests. They continued having unprotected sex for several months, though KM testified she would not have had sex with Cuerrier had she known his HIV status at the outset. A few months later, Cuerrier began a sexual relationship with BH. After their first encounter, BH told him she was afraid of diseases but did not specifically mention HIV. Again, Cuerrier did not disclose that he was HIV-positive. Condoms were not used during most of their 10 or so sexual encounters. BH then discovered Cuerrier had HIV and confronted him. At the time of the trial, neither woman had tested positive for HIV.[38]

Cuerrier was charged with two counts of aggravated assault. Section 265 of the *Criminal Code* sets out the general provision for assault:

> (1) A person commits an assault when
>
> (a) without the consent of another person, he applies force intentionally to that other person, directly or indirectly.[39]

The intentional application of force is not assault if it is consented to. Paragraph 265(3)(c), however, sets out that fraud is one of the conditions vitiating consent:

> 265 (3)(c) For the purposes of this section, no consent is obtained where the complainant submits or does not resist by reason of … fraud.[40]

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[38] *Cuerrier*, *supra* note 1 at para 79; see also *R v Cuerrier* (1996), 3 CR (5th) 330 (BCCA) at para 11 (this is the appeal-level decision with a slightly different factual emphasis).

[39] *Criminal Code*, RSC 1985, c C-46, s 265(1) [*Criminal Code*].

The general assault provision is further refined by subsequent sections, which set out the specific conditions necessary to render assault aggravated or sexual. The example pertinent to *Cuerrier* is laid out in section 268 of the *Criminal Code*:

> (1) Every one commits an aggravated assault who wounds, maims, disfigures or *endangers the life of the complainant*.
>
> (2) Every one who commits an aggravated assault is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.[41]

This provision does not mention HIV or other STIs and, in fact, there are no HIV-specific crimes in Canadian law. Rather, existing offences have been applied in prosecutions to date. This is the preferred strategy of groups who believe penalties specifically aimed at conduct that may transmit HIV will label all individuals with HIV/AIDS as potential criminals and lead to indiscriminate stigma.[42] On the other hand, HIV-specific provisions have the advantage of defining in law the exact conduct prohibited, rather than leaving this task to courts. Limiting prosecutorial or judicial discretion in this way could check over-extension and misapplication of the criminal law. It is worth noting that diverse charges, with maximum penalties ranging from five years to life imprisonment, have been laid against people with HIV whose conduct posed a risk of transmission. These include: assault, aggravated assault, sexual assault, sexual assault causing bodily harm, aggravated sexual assault, common nuisance, criminal negligence causing bodily harm, murder, attempted murder, and uttering threats. The application of such a wide range of charges is controversial. For example, charges of common nuisance–which require conduct that "endangers the lives, safety, property, or comfort of the public"[43]–have been successfully laid against HIV-positive individuals for engaging in a single act

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[40] *Ibid* s 265(3)(c).

[41] *Ibid* s 268 [emphasis added].

[42] Richard Elliott, "Criminal Law, Public Health and HIV Transmission: A Policy Options Paper" (Geneva: UNAIDS, 2002) at 32 [Elliott, "Policy Options"]; World Health Organisation European Region, "WHO Technical Consultation on the Criminalization of HIV and Other Sexually Transmitted Infections" (Copenhagen: WHO, 2006) at 8, online: <www.euro.who.int/aids> [WHO Technical Consultation].

[43] *Criminal Code*, *supra* note 39 s 180.

of unprotected sex.[44] In general, it is best that criminalization be carried out using general provisions, subject to the existence of consistent prosecutorial guidelines and predictable judicial interpretation (as should be the case with any criminal charge). This provides both flexibility and a clear delineation of prohibited conduct while sidestepping allegations of HIV/AIDS exceptionalism and avoiding the provisions becoming a stigmatizing force.

B. The Criminalization of Non-Disclosure and the Purposes of Criminal Law

It is trite to state that the criminal law is a blunt, naked exercise of State power, used to deprive an individual of his freedom only in both serious and blameworthy circumstances. The decision to deploy the criminal law must be justified with an eye to the four main objectives of criminalization: incapacitation, rehabilitation, retribution, and deterrence.[45] Factors unique to STI transmission that militate against achieving these goals are analyzed below:

i) *Incapacitation:* Imprisoning convicted criminals is said to incapacitate offenders for the length of their jail term, preventing them from harming others. In the case of HIV transmission by a repeat offender who refuses to comply with repeated public health orders to practice safer sex and inform partners, as was the case in *Cuerrier,* this may well be true.[46] However, imprisonment could conceivably have the opposite effect on public health. Prisons are places of heightened HIV prevalence in which high-risk behaviour is common.[47] Prisoners may also receive conjugal visits from partners who live among the general public, linking the two populations. However, it is important to note the difference from a criminal law perspective between, on the one hand, reducing the spread of HIV by any method, and, on the other, targeting exposure or transmission through sexual behaviour and non-disclosure, which might be considered dishonest, and thus worthy of a criminal law response.

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[44] Canadian HIV/AIDS Legal Network, "Criminal Law and HIV" (2008), online: <www.aidslaw.ca/publications/publicationsdocEN.php?ref=847> at Part II [Canadian HIV/AIDS Legal Network, "Criminal Law and HIV"].

[45] Elliott, "Policy Options" *supra* note 42 at 20.

[46] *Cuerrier*, *supra* note 1 at 141.

[47] *PHAC Updates*, *supra* note 5 at 119.

ii) *Rehabilitation:* There is some debate whether criminal prosecutions serve rehabilitative functions in relation to sexual risk-taking behaviours. These behaviours are complex and may be more effectively influenced in the long-term using non-coercive interventions, such as counselling or support that address the underlying reasons for engaging in them. However, the likelihood of rehabilitation during imprisonment for *any* crime has long been questioned and is largely contingent on the allocation of resources to this end, both within prisons and in outside communities. Framed in this way, any problem of rehabilitation is not one created by the criminalization of HIV transmission in particular, but is part of a larger set of questions involving the operation of the justice system as a whole.

iii) *Retribution:* A principal justification for criminalization is the punishment of morally blameworthy behaviour. This in itself could be sufficient reason for criminalization, independent of public health efforts or other consequentialist justifications. The fulfillment of this objective depends on determining which behaviours involve a "guilty mind" of sufficient moral culpability to merit retribution.

iv) *Deterrence:* Another argument in favour of criminalization is that it deters people from conduct that transmits or risks transmitting HIV. This goal is motivated by public safety concerns. However, it is not entirely clear that criminal charges are effective in changing behaviours that occur "in the heat of the moment." Some authors have compared criminalizing the intended transmission or knowing non-disclosure of HIV to failed attempts to prohibit the consumption of alcohol and other drugs, consensual homosexual sex, or prostitution. These prohibitions led to stigma, concealment, and arguably greater harm than would have occurred had less emphasis been placed on achieving a deterrent effect.[48]

Because the strongest effect of incapacitation is experienced by a few serious offenders, the retributive and deterrent functions of the criminal law offer the strongest generalizable, though qualified, points in favour of criminalizing the intended transmission or knowing non-disclosure of HIV.

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[48] Elliott, "Policy Options" *supra* note 42 at 21.

However, it is also important to consider section 718 of the *Criminal Code,* which describes two additional purposes of sentencing: (i) providing "reparations for harm done to victims or to the community"; and (ii) promoting "a sense of responsibility in offenders, and acknowledgment of the harm done to victims and to the community."[49] A criminal prosecution for the intended transmission or knowing non-disclosure of HIV might not only satisfy a public interest in punishment, but also provide a sense of interpersonal justice to victims who feel personally targeted and violated.

A final point not often raised by anti-criminalization groups is that criminal law, much like tort law, sends messages about what society considers to be morally wrongful behaviour.[50] As the Alberta Court of Appeal said in an early non-disclosure case:

> Concern has been expressed as to the message which this sentence sends to carriers of the AIDS virus. That message is that anyone who knowingly exposes another person to the risk of contracting AIDS, having in mind the seriousness of that risk, must expect to receive a substantial period of imprisonment.[51]

In contrast to deterrence, which operates through fear of criminal sanctions, these messages can legitimate discourses that press for mutual disclosure and the use of protection among partners. Criminal law sanctions can also be a

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[49] *Supra* note 39 ss 718 (e)-(f).

[50] Indeed, another consideration that might frame the decision of whether and how to criminalize the knowing transmission or non-disclosure of HIV and other STIs is the existence of tort remedies. Though no definitive judgment on sexual transmission of or exposure to an STI has been rendered by a Canadian court, *ter Neuzen v Korn* ([1995] 3 SCR 674) and *Pittman Estate v Bain* ((1994), 112 DLR (4th) 257, 19 CCLT (2d) 1) seem to suggest that the negligent transmission of an STI (in both of these cases, HIV) is actionable under tort law. However, until there is a case directly concerned with the transmission of, or perhaps mere exposure to, a sexually transmitted illness, this avenue of redress remains hypothetical. Potential torts which might be invoked by the plaintiff to cover physical harm include battery and assault for cases of knowing or willfully reckless transmission, while negligence would cover cases of merely negligent transmission. Mental suffering could be compensated through the tort of outrage (also known as intentional infliction of emotional distress), or perhaps the tort of harassment (also known as negligent infliction of emotional distress). For a recent review of whether the tort of harassment exists in Canadian law, see *Mainland Sawmills Ltd v IWA-Canada*, 2006 BCSC 1195 at paras 12-16, 152 ACWS (3d) 543.

[51] *R v Summer* (1989), 69 Alta LR (2d) 303 at 303, 99 AR 29, 73 CR (3d) 32 (Alta CA) (Summer was sentenced to one year in prison on a charge of creating a common nuisance).

powerful public relations tool in the hands of non-governmental organizations. Campaigns against drunk driving provide an example of how advocacy groups have used the strong condemnation of criminal law not to prohibit the consumption of alcohol itself, but to shape its behavioural expression and the discourse surrounding it to encourage safer behaviour.

C. A Response to Public Health Concerns Opposing Criminalization

To this analysis of objectives internal to the criminal law we must add an examination of countervailing policy concerns. Naturally, the criminal law seeks to provide a net moral or practical gain to society, and must, to some extent, justify and tailor its responses with reference to outcomes. It is here that the possible spread of HIV among the population may be considered. What follows are widely-cited problems criminalization is believed to create or exacerbate:[52]

i) *Disincentive to testing:* The criminal law's ability to deter risky behaviour could be outweighed by harm to public health if people are *also* deterred from testing for STIs due to the fear of criminal prosecution. Anonymous testing has been instrumental in encouraging people to test and seek treatment without risking discrimination, a breach of confidentiality, or the creation of an official record that is disclosed to public health authorities. Criminalization may provide a disincentive for STI testing if prosecution hinges on a person's knowledge of his or her HIV status. If a person remains ignorant, he might not be successfully convicted.

However, the impact of criminalization on a person's willingness to test has not been evaluated directly. Instead, the argument is made by comparison to non-anonymous testing which can result in loss of confidentiality, stigma, and discrimination.[53] In light of the lack of such evidence, the majority in *Cuerrier* was correct in preferring Professor Holland's opinion:

> Individuals will not be deterred from testing just because of the possibility that at some future stage they may face criminal liability. … People want to know whether they are infected or not and whether any treatment is available. *Fear of possible*

[52] Elliott, "Policy Options" *supra* note 42 at 24; Canadian HIV/AIDS Legal Network, "Criminal Law and HIV", *supra* note 44 at sheet 3.

[53] See Elliott, *ibid* at 25 n 37.

> *future prosecution for something which has not yet occurred is most unlikely to deter anyone from being tested*.[54]

ii) *Hindering access to counselling and support:* Criminalizing the conduct of those infected with HIV could affect their willingness to seek out social services, including counsellors who are instrumental in altering highly complex behaviour by offering psychological or psychiatric support. If ongoing criminal actions are discussed with counsellors, to what extent could records or testimony be compelled in court for use against infected individuals? The level of legal protection for the confidentiality of treatment information or communications to professionals has been mixed, and this could have a chilling effect on diagnosed individuals' willingness to seek out counselling or disclose information to others. In common law jurisdictions, only the lawyer-client relationship is absolutely privileged, while confidential medical information may be protected or compelled on a case-by-case basis, according to four policy criteria.[55] In Quebec, statutory privilege may extend to all professional relationships, but it cannot apply to criminal proceedings, since they are a federal matter.[56] Disclosure of information obtained from a counselling session in a criminal proceeding has been implicitly approved by the Supreme Court in the case of *R v RS*, which was denied leave to appeal from the Ontario Court of Appeal, despite anti-disclosure policy considerations based on confidentiality and therapeutic benefit that were set out in the judgment.[57] Though no ruling related to confidentiality in the situation of HIV non-disclosure has been made, it can be assumed that disclosure of these records might be ordered in some situations. Of course, for this to be true, the HIV-diagnosed indi-

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[54] *Cuerrier*, *supra* note 1 at para 143, citing Winifred H Holland "HIV/AIDS and the Criminal Law" (1994) 36 Crim LQ 279 [emphasis added].

[55] See *R v Gruenke*, [1991] 3 SCR 263. See also *M (A) v Ryan*, [1997] 1 SCR 157; *Slavutych v Baker*, [1976] 1 SCR 254.

[56] *Charter of Human Rights and Freedoms*, RSQ c C-12, s 9; *Medical Act*, RSQ c M-9, s 42.

[57] *R v RS* (1985), 19 CCC (3d) 115, (*sub nom R v RJS*) 45 CR (3d) 116 (Ont CA). For a more thorough discussion of confidentiality, see Richard Elliott, "After *Cuerrier*: Canadian Criminal Law and the Non-Disclosure of HIV-Positive Status" (Montreal: Canadian HIV/AIDS Legal Network, 1999) at 57-64 [Elliott, "After *Cuerrier*"].

vidual would have to be facing criminal charges after discussing activities of this nature with his counsellor. It is unclear to what extent this would affect the core counselling relationship or efforts to encourage lower-risk behaviours.

iii) *Creating a false sense of security and undermining individual responsibility:* There is a danger that criminally prosecuting people for not disclosing their HIV-positive status might encourage a false sense of security among those who are, or believe themselves to be, HIV-negative, leading to overall riskier behaviour. The belief that criminal prosecutions ensure disclosure undermines the message that individuals should always practice safer sex and obtain adequate information from a partner, which is quite problematic given the number of people referred to in Part II who are unaware of their infection.

However, it has not been demonstrated that criminalization would have this effect on decisions regarding safer sex, particularly in light of concern over other undesirable STIs. On the contrary, high-profile prosecutions might highlight the problem of non-disclosure as a serious one and carry the message that despite silence or repeated denials, any partner might be infected. In addition, as Justice Cory points out for the majority in *Cuerrier*, criminalization in this case is a situation-specific shift in responsibility: "It is true that all members of society should be aware of the danger and take steps to avoid the risk. However, the *primary responsibility* for making the disclosure must rest upon *those who are aware* they are infected."[58] Finally, there is no reason why public health campaigns promoting lower-risk behaviours, mutual disclosure, and individual responsibility for health cannot continue in the presence of criminalized non-disclosure.

iv) *Spreading misinformation about HIV/AIDS*: Inappropriate and overly-broad prosecutions can contribute to public misunderstandings about how HIV is transmitted and the level of risk presented by various sexual activities. Abroad, criminal charges have been laid and convictions obtained in cases involving biting, scratching, and spitting, despite an extraordinarily low or non-existent risk of transmission.[59] The

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[58] *Cuerrier*, *supra* note 1 at para 144 [emphasis added].

[59] Elliott, "Policy Options" *supra* note 42 at 24.

Canadian case of *R v Thissen*[60] resulted from a similar situation: the defendant bit the complainant on the hand, causing a bleeding wound, and then disclosed that she had HIV. Thissen was convicted of aggravated assault under section 268 of the *Criminal Code*, which requires the complainant's life be endangered, and was given a two-year sentence. It is acknowledged that this type of judicial error, coupled with sensationalist media coverage, can contribute to a dangerously misinformed public. However, these occurrences have been rare and future problems may be avoided by following the judicial guidelines outlined in Part IV of this paper.

v) *Increasing stigma and discrimination:* Criminal prosecution for transmission or knowing non-disclosure of HIV, along with inflammatory media coverage, can contribute to the stigma faced by those living with HIV. Few infectious diseases are viewed with as much fear as HIV, and diseases more contagious than HIV are nonetheless treated with less repugnance. Criminal prosecution risks portraying all people living with HIV as potential criminals, and, in a disproportionate manner, those identified in the public mind with HIV and already subject to social disapproval: sex workers, MSM (recall that AIDS was originally named "Gay-Related Immune Disease" or GRID),[61] injection drug users, and certain immigrant groups. In *R v Thissen*, for example, the defendant was a transvestite with a lengthy prostitution record and the altercation occurred in the context of a police bust. Media coverage of these criminal charges has also been vigorous and, in some cases, hyperbolic. Reports on charges against one HIV-diagnosed woman in Ontario included headlines such as: "HIV Woman Strikes Again"[62] and "Woman Admits AIDS Assault; Petite Redhead Pleads Guilty to Trying to Sexually Infect CFB Bor-

[60] *R v Thissen*, [1996] OJ no 2074 (QL) (Ont Prov Div).

[61] Lawrence K Altman, "New Homosexual Disorder Worries Health Officials" *The New York Times* (11 May 1982), online: <www.nytimes.com/1982/05/11/science/new-homosexual-disorder-worries-health-officials.html>.

[62] Tracy McLaughlin, "HIV Woman Strikes Again: Cops; Charged with Having Unprotected Sex", *Toronto Sun* (28 February 2007) 4.

den with HIV."[63] These reports not only suggest devious criminality, but also misrepresent the law. In this case, the accused was charged with aggravated sexual assault for non-disclosure. Intent to infect was neither alleged by the Crown nor mentioned in the original sentencing judgment in the judge's list of aggravating and mitigating factors.[64]

Misuse of prosecutorial or judicial discretion, or irresponsible reporting by the media may reflect or reinforce pre-existing stigma and discrimination against individuals living with HIV. However, this possibility applies *mutatis mutandis* to any application of the criminal law and reflects problems with the justice system that are already well-recognized, such as police over-enforcement in Black communities or media reports promoting racialized stereotypes of crime. As Justice Cory points out in *Cuerrier*, this type of stigmatization must be distinguished from the stigma attached to a criminal conviction itself:

> It was also contended that criminalization would further stigmatize all persons with HIV/AIDS. However it cannot be forgotten that the further stigmatization arises as a result of a sexual assault and not because of the disease … To proceed by way of a criminal charge for assault is not to "criminalize" the respondent's activities. Rather, it is simply to apply the provisions of the Code to conduct which could constitute the crime of assault and thereby infringe s. 265.[65]

Opponents of criminalization argue that public health law provides an alternative method of dealing with the problems of intended transmission or knowing non-disclosure of HIV. If public health policies can achieve the objectives listed above, while simultaneously doing less damage to health initiatives or other important interests, the application of the criminal law may be unnecessary and unjustified. How might public health interventions achieve these goals?

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[63] Tracy McLaughlin, "Woman Admits AIDS Assault; Petite Redhead Rleads Guilty to Trying to Sexually Infect CFB Borden with HIV", *Toronto Sun* (26 November, 2005) 4.

[64] *R v Murphy*, 2005 CarswellOnt 8297 (Ont Sup Ct J).

[65] *Cuerrier*, *supra* note 1 at para 145.

It is likely that public health policies are better suited to achieving rehabilitation (i.e. enabling individuals to act with the proper care to avoid HIV transmission or disclose their status) than criminalization. Interventions by public health or support workers outside the penal system can be tailored to fit an individual's situation, including psychological or emotional issues, or the violence that a woman fears may occur if she informs her partner that she is infected. If less intrusive measures fail to deter conduct that places others at risk, public health legislation may also allow for detention orders (i.e. incapacitation) in locations such as hospitals, where less high-risk activity occurs than in prisons, and where health services are more readily available. Again, however, there is no reason public health interventions that encourage and enable disclosure cannot continue alongside the criminalization of non-disclosure.

Some argue that "public health orders may have a deterrent effect on the individuals to whom they apply,"[66] particularly if they are enforceable by the courts and police, while maintaining the subject's liberty in other respects. Thus, according to this view, criminalization is unnecessary. This explanation is tenuous, given the doubt expressed by many of the same advocates about the power of criminal prosecutions to deter crime. It is also crucial to separate the goals of rehabilitation and deterrence for this analysis, since deterrence looks only prospectively to the effect of enforced negative consequences on behaviour. In addition, the criminal law is better suited than public health policies to achieve the retributive function of punishing and publicly denouncing conduct that society finds morally objectionable.

Finally, public health interventions can take on a quasi-criminal character at their extreme. Health officials may have the power to compel examination and medical treatment of people suspected of carrying a transmissible disease, order them to disclose their HIV status to sexual partners, or detain a person (often using the state's police power) if this is demonstrably justified as necessary to prevent disease from being transmitted.[67] These more coercive aspects of public health are, like criminal law, subject to misuse for reasons of stigma or discrimination: "The UN has cautioned against the inappropriate application of provisions in public health laws that may be suited for casually communicable and often curable diseases, but not HIV/AIDS."[68]

Thus, despite the potential weaknesses of the criminal law and the utility of public health interventions, evidence does not support the prima facie exclusion of criminalization as a policy option. Instead, the choice to criminalize

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[66] Elliott, "Policy Options" *supra* note 42 at 29.

[67] See e.g. *Health Protection and Promotion Act*, RSO 1990, c H.7, ss 22, 35-36.

[68] Elliott, "Policy Options" *supra* note 42 at 29.

discrete behaviours should depend on: (i) how one understands their practical and moral gravity as deserving of control or punishment; (ii) the presence of negative effects on public health outcomes or other important interests; and (iii) the possibility of crafting legal provisions and tests with enough precision to render just results.

D. Conceptions of Harm and Stigmatization

The majority in *Cuerrier* quotes Professor Holland regarding the potential for "serious bodily harm" posed by HIV infection: "The consequences of transmission are grave: at the time there is no 'cure'; a person infected with HIV is considered to be infected for life. The most pessimistic view is that without a cure all people infected with the virus will eventually develop AIDS and die prematurely."[69] Indeed, although the life expectancy and quality of life of those who receive HAART treatment has improved dramatically over the past 30 years, and significantly even since the 1998 judgment in *Cuerrier*, those diagnosed with HIV can expect to have a shorter lifespan than an uninfected individual, with higher rates of co-morbidity and mortality.[70] HIV-infected individuals can also experience a number of conditions that do not normally develop in healthy individuals, such as rare cancers and opportunistic infections.[71]

This is not to underemphasize that HIV infection, possibly leading to AIDS, is now a chronic[72] (i.e. a long-term and incurable, but treatable) condition, but simply to reinforce its potentially serious consequences. It is also important to note that the progression of the disease varies widely according to a person's susceptibility, immune function, and other factors including: viral load and CD4 cell count when treatment begins; age; the presence of other infections; and the particular strain of virus and its resistances.[73] HAART is available in Canada but presents difficulties as a collection of medications that

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[69] *Cuerrier*, *supra* note 1 at para 128.

[70] Antiretroviral Therapy Cohort Collaboration, "Life Expectancy of Individuals on Combination Antiretroviral Therapy in High-Income Countries: A Collaborative Analysis of 14 Cohort Studies" (2008) 372:9635 The Lancet 293 [ATCC, "Life Expectancy"].

[71] AIDSmap, "HIV Treatment Prognosis" (February 2010), online: AIDSmap <www.aidsmap.com/cms1044536.aspx> [AIDSmap, "Prognosis"].

[72] David C Dugdale III & Jatin M Vyas, "HIV Infection" (25 January 2011), online: Medline Plus <www.nlm.nih.gov/medlineplus/ency/article/000602.htm>.

[73] AIDSmap, "Prognosis", *supra* note 71.

must be taken in some quantity at regular intervals. Common side effects include nausea, headache, malaise, and fat accumulation on the back ("buffalo hump") and abdomen; when used for a long period of time, these medications also increase the risk of heart attack.[74] Thus, infection with HIV can still be objectively qualified as a "serious bodily harm," even for Canadians receiving advanced care.

However, as one author argues, "by conceiving of HIV infection as merely a species (of serious bodily harm) within a genus (of bodily harms), the criminal law may, additionally, be thought to have avoided the charge of HIV/AIDS exceptionalism."[75] He states that the context of transmission and social meaning of infection–which are explicitly rejected by the narrative of a liberal, positivist theory of law for which legitimacy depends on neutrality and objectivity–is precisely what determines whether it is proper and appropriate to treat those who infect others as having committed a wrong deserving of moral and legal censure. In his opinion, and that of others,[76] this context and meaning form part of a legal framework "that with every conviction affirms the idea that HIV infection is something that is in and of itself harmful, and by implication, that those people who are HIV positive are somehow 'damaged,' 'abnormal' and 'lacking.'"[77] In short, finding recklessness involves a complex relationship between risk and fault and is a matter of individual and *socio-political* judgment, as the risk must be found to have been unjustifiable or unreasonable. The negative judgment of those living with HIV is contributed to by a modern society that constructs fellow human beings as "risks" to our physical, economic, and psychic security. Because infected individuals are categorized as unhealthy and abnormal, they become potential criminals and "harmers."

Also, due to the negative discourses surrounding those who are associated with HIV infection–sex workers, racial minorities, and homosexuals–these groups are portrayed as constituting a threat to mainstream society's self-identify and security, as well as to the values and norms in which these are grounded. This leads to a social explanation of AIDS "which identifies its *causes* with the *practices* that define an *identity* that constitutes a *risk*."[78] As a result, those living with HIV find it impossible to resist accusations that an in-

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[74] David C Dugdale III & Jatin M Vyas, "AIDS" (25 May 2010), online: Medline Plus <www.nlm.nih.gov/medlineplus/ency/article/000594.htm>.

[75] Matthew Weait, *Intimacy and Responsibility: The Criminalization of HIV Transmission* (New York: Glasshouse, 2007) at 113.

[76] WHO Technical Consultation, *supra* note 42 at 7.

[77] Weait, *supra* note 75 at 112.

[78] *Ibid* at 142 [emphasis added].

cident of exposure or onward transmission was *their* responsibility and no other's. HIV is taken as merely a quality of individuals and ignored as a social fact, and the relevance of specific individuals' efforts to act responsibly will be denied.[79]

However, it must be emphasized that the threshold of the legal test for transmission or exposure in Canada remains "serious bodily harm," without which there can be no conviction. If in the future the physical harm caused by HIV infection were to fall below this threshold, regardless of any social stigma, there would be no crime. What's more, one cannot be prosecuted merely for having HIV, but rather for acting in a manner that is considered criminal. It is more difficult to address the points raised by various discourses that criminalization may: construct those living with HIV as abnormal and inherently "risky" (thus constituting the moral wrong of the crime itself); create an offender-victim dyad; preclude the social nature of HIV infection; and deny the relevance of particular individuals' efforts to prevent transmission. First, the desire to avoid risk, especially the risk of contracting an STI more serious than other communicable but curable illnesses, is logical. It is also a fact that those living with HIV, though not inherently "risky," can engage in activities that do pose a heightened risk of transmission. Second, as discussed in Part II, it is difficult for both partners to take complete responsibility for each other's protection, particularly if one of them (the HIV-infected *or* the "victim") is socially marginalized. The reasoning of the law as it stands is that one's knowledge of being infected with HIV, a virus which can lead to devastating illness, creates a situation in which *any* person could realize the wrongfulness of knowingly transmitting or not disclosing. This is no different than any other crime, like theft, which, for social and economic reasons, is invariably committed more often by marginalized individuals. It is not merely having HIV that creates a duty to disclose, rather it is but knowing one is infected and choosing not to take steps to protect or obtain the consent of one's partner. Finally, the Supreme Court has explicitly recognized that the duty to disclose varies with the significance of the risk posed;[80] therefore, efforts to act responsibly, such as choosing lower-risk activities or using a condom, may well be recognized by judges in their decisions.

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[79] *Ibid*.

[80] *Cuerrier*, *supra* note 1 at para 127.

E. Intentional Transmission or Exposure – R v Aziga

Johnson Aziga recently became the first person, perhaps in the world, to be tried and convicted of first-degree murder for the sexual transmission of HIV. He reportedly had unprotected sex with 13 women, despite knowing of his HIV-positive status and having been warned by public health authorities to use protection and disclose his illness. Seven of the women tested positive for HIV, and two later died of AIDS-related cancers. The women alleged that Aziga had infected them with the virus, had not disclosed his status to them before having unprotected sex, and in some cases had actively deceived them. The women claimed they would not have had sex with Aziga had he disclosed. A jury found him guilty of two counts of first-degree murder, 10 counts of aggravated sexual assault, and one count of attempted aggravated sexual assault.[81] Aziga was sentenced to life in prison with no possibility of parole for 25 years, as is mandatory in Canada for a conviction of first-degree murder. He has stated his intention to appeal.

The first two charges were elevated from manslaughter to first-degree murder according to paragraphs 231(5)(b) and (d) of the *Criminal Code*, which provide that in certain contexts–in this case, sexual assault or aggravated sexual assault–all murder is of the first-degree. Though elevation of the charge in the context of HIV infection is debatable, there is nonetheless consensus among many anti-criminalization groups that, should the Crown prove beyond a reasonable doubt that the defendant intended to cause bodily harm that he knew was likely to cause death or was reckless as to whether death ensued, criminal liability is warranted.[82] This fits with the highest of the three levels of mental culpability generally recognized by the criminal law: intent, recklessness, and negligence. A person intends to commit a crime when it is his *purpose* to commit it, or if he *knows* with some certainty his conduct will bring about the prohibited result; this is most clearly included in the scope of the criminal law. However, some authors have stated concern that sensational media reports lead the Crown to pursue more serious attempted murder charges–this is described as the "creep of criminalization"–based solely on the allegation that one has not disclosed his HIV-positive status before unprotected sex.[83] While it is undoubtedly necessary to develop strong prosecutorial guidelines in these cases to ensure charges are consistent (as with any criminal mat-

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[81] Barbara Brown, "Guilty Verdict in Hamilton HIV Murder Case" *Toronto Star* (4 April 2009), online: <www.thestar.com/article/613920>.

[82] Cameron, *Criminalization*, *supra* note 30 at 65; WHO Technical Consultation, *supra* note 42 at 9.

[83] Cameron, *Criminalization*, *supra* note 30 at 65.

ter), courts are also highly sensitive to the requirements of *mens rea*, which the Crown must prove beyond a reasonable doubt. Unduly inflated charges are unlikely to be sustained at trial.

F. Reckless Transmission or Exposure

Whether the criminal law should extend to reckless or negligent conduct in the context of HIV exposure is more contentious. A person is criminally reckless who foresees that particular conduct may cause a prohibited result, but nevertheless deliberately takes the unjustified risk. Lowering the threshold of liability below intentionality raises concerns about the potential for bias in the interpretation of factors relevant to finding recklessness, such as the degree of risk that would be deemed unjustifiable, or what conduct is so far from the conduct of the reasonable person that it could be considered criminal. In spite of these concerns, this Part demonstrates that the criminal provisions for liability and the associated judicial tests can be crafted to safeguard judicial objectivity.

1. Should Exposure Without Transmission be Criminalized?

In England and Wales, criminal charges apply only when there has been HIV transmission (i.e. infection of another person). Exposure is not a ground for prosecution.[84] It is not uncommon for the criminal law to differentiate on the basis of consequence. For example, Canada has separate charges for murder and attempted murder, and for assault and aggravated assault. This is logical when the completion of the crime is thought to indicate a more culpable mental state, a higher cost to society, or the presence of greater risk-taking. By contrast, a number of crimes, such as drunk driving, do not depend on any consequence arising, even in the absence of the more culpable mental states of intention or recklessness. However, there is no provision in the *Criminal Code* that punishes only for the completion of a serious crime, but in no manner for its attempt. While it may be desirable to reduce the overall number of prosecutions dealing with HIV for pragmatic reasons, but the criminalization of transmission and not simple non-disclosure would be morally unjustifiable. Individuals who expose their partner to an unjustifiable risk of infection with recklessness (and therefore *mens rea*) greater or equal to that of other diagnosed individuals who "successfully" transmit would not be captured. Imagine a situation in which Person A repeatedly and through active deception engages partners in unprotected sex but no transmission occurs, while a single unpro-

[84] See generally Weait, *supra* note 75.

tected act without disclosure by Person B leads to HIV infection. Prosecution would depend on chance and could be seen as arbitrary. Criminalization should thus apply equally to both reckless transmission and exposure.

2. Knowledge of Infection as a Precondition for Conviction

For criminal sanctions to apply, the Crown should have to prove the accused actually knew he was infected with HIV. In other words, the Crown would have to prove the accused had positive knowledge of his infection, without which he cannot be said to have acted recklessly. Extending criminalization to those who know they *may* be infected, or who it is felt *ought* to know they are or may be infected would expose far too many to prosecution. It would also allow for constructive knowledge based on existing bias, discrimination, or identity profiling:

> This would have resulted in a significant extension of criminal liability, one from which it is but a small step towards basing liability on membership of a high-prevalence group – on the grounds that gay men, injecting drug users or people from sub-Saharan Africa ought to assume by virtue of these criteria alone that they are, or may be, HIV-positive.[85]

Comments in the recent Supreme Court ruling in *Williams*, dealing with the non-disclosure of HIV infection to a partner after a positive test, demonstrate this incorrect, overly broad approach to determining what level of knowledge is necessary for conviction: "Once an individual becomes *aware of a risk* that he or she has contracted HIV, and hence that his or her partner's consent has become an issue, but nevertheless persists in unprotected sex that creates a risk of further HIV transmission without disclosure to his or her partner, recklessness is established."[86] This language suggests that a definitive diagnosis of HIV infection is not necessary to activate the legal duty to disclose. However, this standard seems difficult to apply: "When does a person become 'aware of a risk' that they might be HIV-positive? What sort of past activities that might have carried a risk of HIV infection will mean that a person is aware of a risk that they have contracted HIV? How significant a risk does it have to

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[85] M Weait & Y Azad, "The criminalization of HIV transmission in England and Wales: questions of law and policy" (2005) 10(2) HIV/AIDS Policy & Law Review 6.

[86] *Williams*, *supra* note 26 at 28 [emphasis added].

be before it becomes 'reckless'?"[87] Indeed, this standard invites the application of serious criminal penalties where a person was truly uncertain, and could allow courts to intensely scrutinize a person's past activities in a manner that would substantiate the fears laid out above regarding stigmatization. A requirement for successful conviction should be actual knowledge or belief of infection, obtained through a positive medical test result, or physical manifestation of disease.

It follows from this conclusion that, in order to establish guilt, an HIV-positive person must understand how HIV can be transmitted and that his conduct carries a risk of causing his partner serious bodily harm. Though for the vast majority of Canadians it might be said that one is grossly negligent for being unaware of these risks, this may not be the case in countries like South Africa, where in 2006 the health minister famously claimed that AIDS could be treated with traditional African remedies, such as garlic, lemon juice, and beetroot.[88] In Canada's multicultural society, courts must be conscious that many will have come from HIV-endemic nations where education is limited, and that even many Canadian-born youth have incorrect views about of the existence of an AIDS vaccine, or the curability of HIV/AIDS.[89] If raised as an issue by the defence, the Crown should be required to prove that an individual possessed knowledge of how HIV is transmitted and its harmful effects, or that the accused was grossly negligent as to knowledge of these facts.

IV. Judicial Interpretation: The Thresholds of Risk and Harm

A. The Split on Fraud in R v Cuerrier

The *Cuerrier* decision focuses solely on the question of whether an HIV-positive person who fails to disclose his status has committed "fraud" as defined by the assault provision of the *Criminal Code*. Seven of nine justices heard the case and all concluded that Cuerrier's failure to disclose his status constituted fraud. The split revolved around how the law should define fraud that vitiates consent to sex. In the previous (repealed) version of the provision, fraud vitiated consent only where it related to the "nature and quality of the

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[87] Canadian HIV/AIDS Legal Network, "Notice re: Supreme Court of Canada decision in *R v Williams*" (18 September 2003), online: <aidslaw.ca/publications/interfaces/downloadFile.php?ref=22>.

[88] Geoffrey York, "Radical shift in HIV-AIDS thinking" *The Globe and Mail* (15 November 2009), online: <www.theglobeandmail.com/news/world/south-africa-radically-shifts-aids-thinking/article1364340>.

[89] *PHAC Updates*, *supra* note 5.

act," or in this case, the mechanical content of the sexual act as opposed to its possible health consequences. The justices agreed that fraud covered in the past by this rule would still vitiate consent, but decided that the operative definition must be extended to cover the situation of the *Cuerrier* case.

The justices adopted three different approaches. The majority, led by Justice Cory, set out a harm-based approach for deciding what would constitute fraud vitiating consent to sex, requiring that the prosecution prove the existence of: (i) an act that a reasonable person would see as *dishonest*; (ii) *deprivation*, or a harm or risk of harm to the complainant as a result of that dishonesty; and (iii) that the complainant would not have consented to the act but for the accused's dishonesty. [90]

Writing for herself and Justice Gonthier, Justice McLachlin concluded the rule of fraud as to the "nature and quality of the act" should simply be expanded to include deceit about STIs:

> Where the person represents that he or she is disease-free, and consent is given on that basis, deception on the matter goes to the very act of assault. The complainant does not consent to the transmission of diseased fluid into his or her body. This deception in a very real sense goes to the nature of the sexual act, changing it from an act that has certain natural consequences (whether pleasure, pain or pregnancy), to a potential sentence of disease or death. It differs fundamentally from deception as to the consideration that will be given for consent, like marriage, money or a fur coat, in that it relates to the physical act itself.[91]

Justice L'Heureux-Dubé proposed that the Court go further, stating that whether the fraud in question was physically harmful or carried a risk of harm is irrelevant. The Crown would be required to prove beyond a reasonable doubt that the accused was dishonest (using an objective standard) with respect to *any* fact in a manner designed to induce the complainant to submit to activity, and that absent this dishonesty, the complainant would not have submitted.

While the two minority approaches seem easier to both define and apply than the harm approach adopted by the majority, Justice McLachlin's approach offers no principled reason for singling out HIV or any other STIs as an additional locus of fraud that potentially vitiates consent (as opposed to any other fraud), and would greatly expand criminal liability. This same problem exists with Justice L'Heureux-Dubé's approach, which her colleagues correctly not-

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[90] *Cuerrier*, *supra* note 1 at paras 112-116.

[91] *Ibid* at para 72.

ed "vastly extends the offence of assault,"[92] and "would trivialize the criminal process by leading to a proliferation of petty prosecutions instituted without judicial guidelines or directions."[93] The approach adopted by Justice Cory– while requiring more thorough interpretation by courts–offers a principle for extending criminal liability, and is more amenable to contextual analysis, the creation of judicial safeguards against abuse, and addressing public health policy concerns. These attributes will be examined in the following Part.

B. How Much (Potential) Harm is Enough?

1. The Elements of Fraud in *R v Cuerrier*: A Sliding Scale of Responsibility

The majority reasons sets out the two requirements for fraud that would vitiate consent: (i) dishonesty and (ii) deprivation. To this first element of dishonesty, Justice Cory assimilates not only deliberate deceit, but also non-disclosure or silence regarding one's HIV-positive status. As he states, "the actions of the accused must be assessed objectively to determine whether a reasonable person would find them to be dishonest."[94] This raises the spectre of stigma and bias entering into the assessment of criminal responsibility; that is, finding an HIV-positive person to be dishonest simply because they are "risky." However, whether dishonesty vitiates consent is decided with reference to the *severity* of the possible bodily harm and the *risk* of its occurrence, creating a sliding scale of responsibility: "The extent of the duty to disclose will increase with the risks attendant upon the act of intercourse. To put it in the context of fraud, the greater the risk of deprivation the higher the duty of disclosure … he Crown will have to establish…a significant risk of serious bodily harm."[95] Justice Cory also added that "[t]he possible consequence of engaging in unprotected intercourse with an HIV-positive partner is death. In these circumstances there can be no basis for distinguishing between lies and a deliberate failure to disclose."[96] *Cuerrier* establishes that the severity of HIV infection creates a positive duty, but raises the following questions: what embodies a legally "significant" risk of transmission? What constitutes a "serious" bodily harm?

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[92] *Ibid* at para 52.

[93] *Ibid* at para 131.

[94] *Ibid* at para 126.

[95] *Ibid* at para 127-28.

[96] *Ibid* at para 126.

2. Policy Considerations: Defining "Serious" and "Significant"

Most agree that HIV infection poses a risk of serious bodily harm. The most common charge laid in cases of non-consensual HIV transmission or exposure is aggravated sexual assault, which requires that the accused "endangers the life of the complainant." This point is rarely, if ever, contested. Notably, the test of serious bodily harm is not exclusive of other severe but generally curable STIs, such as Chlamydia or syphilis. As of yet, few cases have been brought to Canadian courts to test criminal charges for the transmission of or exposure to these other infections.[97] An interesting situation arose in *Williams*, in which the accused was convicted of "*attempted* aggravated assault." Though the accused was deceitful with regard to his HIV-positive status, it was possible that his partner was infected before he became aware of his diagnosis, and thus the Court ruled Williams had not endangered the life of the complainant.[98] However–though it was not accepted at the time–the possibility was raised of an accused individual cross-infecting a complainant with a different, drug-resistant viral strain and thereby further endangering his life.[99] The author believes that in the proper factual circumstances, non-disclosure of potentially cross-infecting HIV infection should be subject to a full conviction for aggravated assault as cross-infection can give rise to a new risk of serious bodily harm.

From the viewpoint of HIV transmission, what constitutes a "significant" risk in law is more complex. It is here that the test set forth by Justice Cory in *Cuerrier* demonstrates its greatest flexibility in incorporating public health goals into criminal law. Intercourse with an HIV-positive person will always present risks, but it is unclear whether lower-risk activities might be considered a "significant" risk. The following chart incorporates the number of infections per 10,000 exposures to an infected source organized by type of *unprotected* exposure route, as well as the categorization of risk with and without condom use:

[97] See e.g. *R v Jones*, 2002 NBQB 340 (dealing with the transmission of Hepatitis C).

[98] *R v Williams*, *supra* note 26.

[99] *Ibid* at 15.

Exposure Route	***Estimated infections per 10,000 exposures to an infected source***[100]	***Categorization of risk (unprotected)***[101]	***Categorization of risk with condom use***[102]
Blood Transfusion	9,000	-	-
Childbirth	2,500	-	-
Needle-sharing (Injection Drug Use)	67	High	-
Percutaneous Needle Stick	30	-	-
Receptive anal intercourse	50	High	Low
Insertive anal intercourse	6.5	High	Low
Receptive penile-vaginal intercourse	10	High	Low
Insertive penile-vaginal intercourse	5	High	Low
Receptive oral intercourse	1	Low	Negligible
Insertive oral intercourse	0.5	Negligible	Negligible
Kissing/Spitting	-	None – low	-

[100] B Varghese et al, "Reducing the Risk of Sexual HIV Transmission: Quantifying the per-act Risk for HIV on the Basis of Choice of Partner, Sex Act, and Condom Use" (2002) 29:1 Sexually Transmitted Diseases 38 at 40.

[101] Canadian AIDS Society, *HIV Transmission: Guidelines for Assessing Risk*, 5th ed (Ottawa: CAS, 2004) at 6, online: <www.cdnaids.ca/web/repguide.nsf/Pages/cas-rep-0307> [*CAS Guidelines*].

[102] *Ibid* at 22-25.

The chart shows that in cases involving kissing or spitting, criminal charges are not appropriate in the absence of aggravating factors. In *R v Edwards*, the trial judge correctly stated that "unprotected oral sex is conduct at a low risk that would not bring it within s. 268(1) of the *Criminal Code*, and had only unprotected oral sex taken place, no charges would have been laid."[103] Indeed, as pointed out in the Canadian AIDS Society risk report, "these categories of HIV transmission are no risk, negligible risk, low risk and high risk. If these categories or levels were represented graphically on a continuous line, negligible and low risk would be much closer to the 'no risk' end of the continuum. There is no 'middle' level of risk."[104] Judicial assessments of the significance of the risk of HIV-transmission should be consistent with available epidemiological data, and thus preclude oral sex, and other low-to-no risk activities from leading to criminal prosecution. This will create consistency in the criminal law, maintain scientific objectivity, and avoid imposing penalties disproportionate to the offence. It would also allow HIV-positive individuals to choose lower-risk activities that accord with public health guidelines and send proper messages to the wider public about the risks of transmission.

V. Recent Applications of *Cuerrier*

A. Condom Use and Viral Load: R v Mabior

In *Cuerrier*, Justice McLachlan specifically mentioned that condom use would preclude a finding of fraud on the part of the accused,[105] while the majority stated that "the careful use of condoms *might* be found to so reduce the risk of harm that it could no longer be considered significant so that there might not be either deprivation or risk of deprivation."[106] This hypothetical statement was considered in the recent case of *R v Mabior*, in which the trial judge concluded that an accused who does not disclose his HIV-positive status can be convicted of aggravated sexual assault even when a condom is used, but that when an accused uses a condom *and* has an undetectable viral load, the risk of harm is so reduced that it cannot constitute fraud.[107] This case was varied on appeal and the court dismissed four of the six counts against Mabior, stating that either "careful or consistent" condom usage *or* "effective" an-

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[103] *Edwards*, *supra* note 19 at para 6.

[104] *CAS Guidelines*, *supra* note 101 at 17.

[105] *Cuerrier*, *supra* note 1 at para 73.

[106] *Ibid* at para 129.

[107] *R v Mabior*, 2008 MBQB 201, 230 Man R (2d) 184, 78 WCB (2d) 380 [*Mabior* (QB)].

tiretroviral treatment (defined as that which renders the viral load in blood undetectable for at least six months) would be sufficient to reduce transmission risks below the level of significance required for conviction by the test in *Cuerrier*.[108] Leave to appeal to the Supreme Court of Canada has been granted as of the time of writing.

A problem with both these rulings is their reliance on viral load as an element necessary or sufficient to escape a finding of fraud. An undetectable viral load (only recently achievable as a result of HAART) significantly decreases the risk of transmission.[109] Yet, as a recent article points out, viral load poses several problems: (i) we cannot yet establish the precise transmission risk for someone with an undetectable viral load; (ii) it is unclear how often and how close to the sexual act one would have to be tested in order to establish a pattern of undetectability;[110] (iii) it is unclear on whom the burden of proof would lie–would an undetectable viral load act as a defence the accused must put forward or would the Crown be required, almost impossibly, to prove beyond a reasonable doubt that the accused's viral load was *not* undetectable at the time of sexual activity; and (iv) considering viral load in liability might open the door to HIV-positive individuals making their own risk-assessments about transmissibility and disclosure.[111] As an example of this last point, studies indicate that optimism about new HIV therapies is linked with sexual risk-taking among MSM.[112] Above all, accepting viral load as negating a finding of fraud in the current state of scientific knowledge would introduce uncertainty into the criminal law, and require courts to make arbitrary distinctions as to what level of viral load is acceptable, either as a single factor (though the trial judge in *Mabior* rejected this argument), or in combination with condom use. For the time being, courts should base any determination of fraud and criminal liability on condom use alone.

The judge in *Mabior* relied on expert testimony that condoms have a failure rate of up to 20% without an explanation of what this figure means; that is, whether it describes breakage and improper use, a condom not providing

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[108] *R v Mabior*, 2010 MBCA 93, leave to appeal to SCC granted, 33976 (5 May 2011) [*Mabior* (CA)].

[109] Julio SG Montaner et al, *supra* note 31.

[110] *Supra* note 108 at paras 111-113 (Several difficulties in this respect are acknowledged in the appeal judgment itself).

[111] Isabel Grant, "Rethinking Risk: The Relevance of Condoms and Viral Load in HIV Nondisclosure Prosecutions" (2009) 54 McGill LJ 389 at 401-403.

[112] *Ibid*.

100% protection against HIV even when used properly, or a 20% risk of transmission. It is here that arguments for and against holding that the use of a condom negates a finding of fraud are laid bare. Condoms do have a risk of failure, so the issue becomes: who should bear this risk? On the one hand, our instinctive belief might be that the HIV-negative partner should be allowed to decide whether he wishes to run the risk of condom failure in the context of possible infection, and that disclosure would be the most honest course in preservation of his autonomy. However, short of abstinence, condom use is one of the best-known ways to prevent the transmission of HIV and is at the centre of modern public health campaigns. It is also important to keep in mind the difficulties involved with disclosure, and that the focus in criminal law after *Cuerrier* is on the risk-taking behaviour of the accused and corresponding moral blameworthiness. It would be problematic to find an HIV-positive person reckless and convict him of the serious criminal charge of aggravated (sexual) assault when he took largely effective steps recommended by public health bodies to protect his partner. On balance, this is a situation in which the sliding scale set out in *Cuerrier*, despite any moral reservations, should accommodate policy considerations and recognize the low-risk classification of protected sexual activities as a bar to criminal liability.

A final question about the duty to disclose arises with respect to low-to-no risk or protected sexual activities that are engaged in repeatedly with the same partner. Statistically, the risk of transmission associated with a single instance of these activities is small and the activity is classified as low-risk. However, over a number of such acts, the cumulative statistical risk of transmission may be more significant, and may even approach that of an unprotected, high-risk activity. In this case, the diagnosed individual would have had a number of opportunities to discuss HIV infection with his partner and disclose. Though feelings of love or attachment over the long term may make this more difficult–or on the contrary, engage our sense of obligation to protect a partner–the underlying logic favouring criminalization is unchanged. In the face of a potentially deadly virus, the diagnosed individual must bear the burden of disclosure when his activity poses a significant risk of serious bodily harm; prolonged non-disclosure should be considered dishonesty. Unlike single activities, which dichotomize neatly into high- and low-risk categories, it would be up to courts to determine at what point the ongoing behaviour should be considered reckless and attract criminal liability, which will be highly fact-specific.

B. HAART and "Serious Harm" R v JAT

On May 7, 2010 the British Columbia Supreme Court released its judgment in the case of *R v JAT*.[113] The accused was charged after engaging in three acts of unprotected anal intercourse with his partner during the latter part of their 10-month relationship and misrepresenting his HIV-positive status. Recall that the duty to disclose operates on a "sliding scale" that is proportionally responsive to both the magnitude of possible harm and the risk of its occurrence.[114] The ruling is significant, as it proposes a re-evaluation of the *Cuerrier* test of what constitutes a "significant risk of serious bodily harm," a question that goes to the elements of endangerment of life and lack of consent, both of which the Crown must prove to convict for aggravated sexual assault.

The judge began her analysis by stating that in *Cuerrier*, "Cory J. did not expressly address the likelihood of transmission of the virus on the facts of that case, focusing instead on the magnitude of potential harm,"[115] in particular, "the potentially lethal consequences of [HIV] infection."[116] The trial judge emphasized that since the ruling in *Cuerrier*, advances in treatment have altered the nature of the harm caused by HIV and tempered its severity. While acknowledging that the drugs used to treat HIV continue to have side effects that can make an HIV-positive person more susceptible to heart, liver, and kidney problems, the judge accepted medical evidence that "the side effects associated with *future* classes of drugs are expected to be even less marked than they are today … [hence] HIV is no longer synonymous with AIDS and premature death … [and] those living with HIV who receive treatment have a normal life expectancy."[117] It is clear that this conclusion had an effect on her subsequent analysis of the severity of harm required to establish deprivation.

In Part III of this paper, it was acknowledged that in many cases HIV has become a chronic, manageable condition. However, without deeply analyzing the content of scientific literature (which is beyond the scope of this work) a number of current studies on the effects of HAART still point to significantly shorter life expectancy among those infected with HIV, who also suffer ongoing detriment to health and well-being.[118] In this light, the general conclusion

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[113] *R v JAT*, 2010 BCSC 766 [*JAT*].

[114] *Cuerrier*, *supra* note 1 at para 128.

[115] *JAT*, *supra* note 113 at para 19.

[116] *Cuerrier*, *supra* note 1 at para 95.

[117] *JAT*, *supra* note 113 at para 22-23 [emphasis added].

[118] ATCC, "Life Expectancy" *supra* note 70. See also Margaret May et al, "HIV Treatment Response and Prognosis in Europe and North America in the First Dec-

against serious bodily harm reached by the judge in *JAT* is questionable and contradicts the findings by the Manitoba Court of Appeal in *Mabior*, released later that same year.[119] Our medical understanding of HIV has allowed us to significantly delay the onset of AIDS and premature death, while its social meaning is also beginning to change, albeit more slowly. However, that contracting HIV no longer leads immediately to systemic secondary infections and swift death does not seem to contradict the statement in *Cuerrier* regarding its potentially lethal consequences. A positive health outcome remains dependent on a number of variables unique to the individual, and the manageability and day-to-day consequences of HIV infection have not yet approached those of any other STI. With this in mind, taking in to account the effects of hypothetical pharmaceuticals seems intuitively unjust and making more than minor adjustments to the sliding scale of responsibility on this basis is premature.

The judge in *JAT* then turned to the risk of infection in this particular case and determined it was insufficient to warrant a criminal conviction for aggravated sexual assault. In arriving at this outcome, she took account of the accused's viral load (which was not suppressed at the time), the fact that the complainant was uncircumcised (which slightly increases the risk of transmission), and that the accused was exclusively the receptive partner and the complainant, the insertive partner. The accepted risk of transmission to the complainant was 4 in 10,000 per act of anal intercourse for a cumulative risk of 12 in 10,000 or 0.12% over the three unprotected acts.[120] This rate is slightly lower than that prescribed by the risk chart set out above.[121] The judge then went on to consider the risk of transmission in other cases. In *Cuerrier*, with respect to the second complainant, the accused was convicted after engaging in 10 acts of intercourse, four or five of which were without a condom. According to the chart presented in Part IV.B(2), this would amount to a 0.4-0.5% risk;[122] in *R v Wright*, a recent decision of the British Columbia Court of Appeal, a 0.5% risk was held to be significant.[123] Meanwhile, several cases such as *Mabior*,[124]

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ade of Highly Active Antiretroviral Therapy: A Collaborative Analysis" (2006) 368: 9534 Lancet 451; Elisa Lloyd-Smith et al, "Impact of HAART and Injection Drug Uses on Life Expectancy of two HIV-Positive Cohorts in British Columbia" (2006) 20:3 AIDS 445; Viviane D Lima et al, "Continued Improvement in Survival Among HIV-Infected Individuals with Newer Forms of High Active Antiretroviral Therapy" (2007) 20:6 AIDS 685.

[119] *Mabior* (CA), s*upra* note 108 at para 64.

[120] *JAT*, *supra* note 113 at 29.

[121] Varghese, *supra* note 100.

[122] *Ibid* at 40.

[123] *R v Wright*, 2009 BCCA 514, 256 CCC (3d) 254.

Cuerrier,[125] and *R v Thornton*[126] seem to indicate–without referring to specific rates of transmission–that any risk beyond the *de minimis* level might be considered significant enough to attract liability.[127]

The finding that a 0.12% risk of transmission over three acts of insertive anal intercourse should not attract criminal liability has far-ranging consequences. On this standard, a number of acts categorized as high-risk by sexual health organizations, including several acts of insertive anal or any type of penile-vaginal intercourse, would not be captured even if transmission occurs.[128] A dichotomy in legal treatment might also emerge between receptive and insertive partners to anal sex. The insertive HIV-diagnosed partner would be subject to criminal charges after a single sex act, while the receptive partner would avoid them after engaging in several unprotected acts. It is the opinion of the author that the judgment in *JAT* goes too far, in that it is not consistent with current sexual health risk guidelines, particularly with respect to condom use as a primary risk-reduction method, and it overstates the positive effects of HAART on the life expectancy and quality of life of HIV-infected individuals. As a result, the decision raises the threshold of risk significance to a level that does not criminalize morally-blameworthy behaviour. Future rulings in this area might more carefully adjust the level of risk required to attract criminal liability to accord with updated public health guidelines.

Conclusion

The overall thrust of this paper has been that criminalizing the intended transmission or knowing non-disclosure of HIV can be appropriate Canadian criminal law policy. In so doing, it is important to contextualize HIV as an infection that affects social groups disproportionately; recall that the criminal law must account for our indeterminate understanding of responsibility for sexual health and the particular difficulties faced when attempting to disclose or self-protect in the sexual realm. Criminalization in this context can nonetheless satisfy several legal goals without denying the importance or undermining

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[124] *Mabior* (QB), *supra* note 107.

[125] *Cuerrier*, *supra* note 1.

[126] (1991), 82 CCC (3d) 530.

[127] It is interesting at this point to compare these developments with the Supreme Court's approach to tort law causation, specifically its treatment of the material contribution test and *de minimis* risks of harm: *Athey v Leonati*, [1996] 3 SCR 458. See also *Hanke v Resurfice*, 2007 SCC 7, [2007] 1 SCR 333.

[128] Varghese, *supra* note 100; *CAS Guidelines*, *supra* note 101.

the realization of wider public health objectives, and thus it should not be excluded prima facie as a valid public policy response. Instead, criminalization should be tailored to reflect our understandings of moral culpability, advances of medical science, the realities of sexual behaviour, and the ongoing efforts of public health campaigns. This tailoring can be achieved in most conceivable situations through successful judicial interpretation of the tests for risk and harm set out a dozen years ago by the majority in *Cuerrier* and by establishing strong prosecutorial guidelines. Doing so will ensure that criminalizing the intended transmission or knowing non-disclosure of HIV remains proportionate to the possible harm created and achieves a balance between public objectives. Finally, though this paper limited itself to criminalization in the context of sexual transmission of HIV, the judgment in *Cuerrier* and related suggestions may have implications with regard to other STIs and situations ranging from injection drug use, *in utero* mother-to-child transmission, breastfeeding, and blood transfusion to disclosure requirements in healthcare settings.[129] The impact of the criminalization of non-disclosure in each of these scenarios presents an important avenue for future study.

[129] For a discussion of some of these issues, see Elliott, "*After* Cuerrier", *supra* note 57 at 32-50.

PNEUMOCYSTIS PNEUMONIA – LOS ANGELES

Centers for Disease Control and Prevention *

In the period October 1980-May 1981, 5 young men, all active homosexuals, were treated for biopsy-confirmed *Pneumocystis carinii* pneumonia at 3 different hospitals in Los Angeles, California. Two of the patients died. All 5 patients had laboratory-confirmed previous or current cytomegalovirus (CMV) infection and candidal mucosal infection. Case reports of these patients follow.

Patient 1: A previously healthy 33-year-old man developed *P. carinii* pneumonia and oral mucosal candidiasis in March 1981 after a 2-month history of fever associated with elevated liver enzymes, leukopenia, and CMV viruria. The serum complement-fixation CMV titer in October 1980 was 256; in May 1981 it was 32. The patient's condition deteriorated despite courses of treatment with trimethoprim-sulfamethoxazole (TMP/SMX), pentamidine, and acyclovir. He died May 3, and postmortem examination showed residual *P. carinii* and CMV pneumonia, but no evidence of neoplasia.

Patient 2: A previously healthy 30-year-old man developed *p. carinii* pneumonia in April 1981 after a 5-month history of fever each day and of elevated liver-function tests, CMV viruria, and documented seroconversion to CMV, i.e., an acute-phase titer of 16 and a convalescent-phase titer of 28* in anticomplement immunofluorescence tests. Other features of his illness included leukopenia and mucosal candidiasis. His pneumonia responded to a course of intravenous TMP/.SMX, but, as of the latest reports, he continues to have a fever each day.

Patient 3: A 30-year-old man was well until January 1981 when he developed esophageal and oral candidiasis that responded to Amphotericin B treatment. He was hospitalized in February 1981 for *P. carinii* pneumonia that re-

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* On 5 June 1981, the Centers for Disease Control and Prevention published a report of *Pneumocystis carinii* pneumonia in the *Morbidity and Mortality Weekly Report*. This report has since been acknowledged as the first published account of what would become known as human immunodeficiency virus and acquired immunodeficiency syndrome.

Original Citation: Centers for Disease Control and Prevention, "Pneumocystis Pneumonia – Los Angeles" (1981) 30:21 Morbidity and Mortality Weekly Report 250.

sponded to TMP/SMX. His esophageal candidiasis recurred after the pneumonia was diagnosed, and he was again given Amphotericin B. The CMV complement-fixation titer in March 1981 was 8. Material from an esophageal biopsy was positive for CMV.

Patient 4: A 29-year-old man developed *P. carinii* pneumonia in February 1981. He had had Hodgkins disease 3 years earlier, but had been successfully treated with radiation therapy alone. He did not improve after being given intravenous TMP/SMX and corticosteroids and died in March. Postmortem examination showed no evidence of Hodgkins disease, but *P. carinii* and CMV were found in lung tissue.

Patient 5: A previously healthy 36-year-old man with clinically diagnosed CMV infection in September 1980 was seen in April 1981 because of a 4-month history of fever, dyspnea, and cough. On admission he was found to have *P. carinii* pneumonia, oral candidiasis, and CMV retinitis. A complement-fixation CMV titer in April 1981 was 128. The patient has been treated with 2 short courses of TMP/SMX that have been limited because of a sulfa-induced neutropenia. He is being treated for candidiasis with topical nystatin.

The diagnosis of *Pneumocystis* pneumonia was confirmed for all 5 patients antemortem by closed or open lung biopsy. The patients did not know each other and had no known common contacts or knowledge of sexual partners who had had similar illnesses. Two of the 5 reported having frequent homosexual contacts with various partners. All 5 reported using inhalant drugs, and 1 reported parenteral drug abuse. Three patients had profoundly depressed *in vitro* proliferative responses to mitogens and antigens. Lymphocyte studies were not performed on the other 2 patients.

Reported by MS Gottlieb, MD, HM Schanker, MD, PT Fan, MD, A Saxon, MD, JD Weisman, DO, Div of Clinical Immunology-Allergy; Dept of Medicine, UCLA School of Medicine; I Pozalski, MD, Cedars-Mt. Siani Hospital, Los Angeles; Field services Div, Epidemiology Program Office, CDC.

Editorial Note: *Pneumocystis* pneumonia in the United States is almost exclusively limited to severely immunosuppressed patients. The occurrence of pneumocystosis in these 5 previously healthy individuals without a clinically apparent underlying immunodeficiency is unusual. The fact that these patients were all homosexuals suggests an association between some aspect of a homosexual lifestyle or disease acquired through sexual contact and *Pneumocystis* pneumonia in this population. All 5 patients described in this report had laboratory-confirmed CMV disease or virus shedding within 5 months of the diagnosis of *Pneumocystis* pneumonia. CMV infection has been shown to induce transient abnormalities of *in vitro* cellular-immune function in otherwise

healthy human hosts (2,3). Although all 3 patients tested had abnormal cellular-immune function, no definitive conclusion regarding the role of CMV infection in these 5 cases can be reached because of the lack of published data on cellular-immune function in healthy homosexual males with and without CMV antibody. In 1 report, 7 (3.6%) of 194 patients with pneumocystosis also had CMV infection' 40 (21%) of the same group had at least 1 other major concurrent infection (1). A high prevalence of CMV infections among homosexual males was recently reported: 179 (94%) had CMV viruria; rates for 101 controls of similar age who were reported to be exclusively heterosexual were 54% for seropositivity and zero fro viruria (4). In another study of 64 males, 4 (6.3%) had positive tests for CMV in semen, but none had CMV recovered from urine. Two of the 4 reported recent homosexual contacts. These findings suggest not only that virus shedding may be more readily detected in seminal fluid than urine, but also that seminal fluid may be an important vehicle of CMV transmission (5).

All the above observations suggest the possibility of a cellular-immune dysfunction related to a common exposure that predisposes individuals to opportunistic infections such as pneumocystosis and candidiasis. Although the role of CMV infection in the pathogenesis of pneumocystosis remains unknown, the possibility of *P. carinii* infection must be carefully considered in a differential diagnosis for previously healthy homosexual males with dyspnea and pneumonia.

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McGill Journal of Law and Health ~ Revue de droit et santé de McGill

PALLIATIVE CARE: AN ENFORCEABLE CANADIAN HUMAN RIGHT?

Yude M Henteleff, Mary J Shariff & Darcy L MacPherson *

This article lays out a series of approaches for establishing an enforceable human right to palliative care in Canada. The article first examines international human rights instruments to which Canada is a signatory, and concludes that they offer limited assistance to palliative care advocates. The article then examines two promising *Charter* challenges. The first, based on section 15, argues that since palliative care is provided unevenly to those who require it, the equality provisions of the *Charter* could compel equitable provision of palliative care to Canadians with life-limiting illnesses. The second is based on section 7, and argues that failure to provide palliative care may impose an unacceptable level of psychological stress on those at the end of life. The article concludes with a look at the limitations of a *Charter* challenge, includ-

Cet article présente une série d'approches permettant d'établir un droit humain aux soins palliatifs au Canada. L'article examine d'abord des instruments internationaux relatifs aux droits de l'homme signés par le Canada et conclut qu'ils sont d'une aide limitée pour les militants des soins palliatifs. Ensuite, les auteurs s'attardent à deux contestations possibles fondées sur la *Charte*. La première, découlant de l'article 15, prétend qu'une disponibilité inégale aux soins palliatifs parmi ceux qui en ont besoin va à l'encontre du principe d'égalité qui forcerait donc à assurer une disponibilité équitable aux soins palliatifs pour les canadiens qui souffrent de maladies mortelles. La seconde se fonde sur l'article 7 de la *Charte* et indique que l'impossibilité de bénéficier des soins palliatifs peut entraîner des niveaux inacceptables de stress

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ing justification under section 1 of the *Charter*, and the lack of empirical evidence necessary to conclusively prove the arguments advanced under sections 15 and 7.

psychologique chez ceux qui se trouvent en fin de vie. L'article se termine avec un regard sur les limites d'une contestation fondée sur la *Charte*, incluant une justification selon l'article 1, ainsi que le manque de preuves empiriques nécessaires pour prouver les arguments fondés sur les articles 15 et 7 de manière concluante.

Introduction

The relief of suffering is a goal common to both medicine and human rights,[1] and although as a global community we have been expressly seeking to identify palliative care as a human right for many years, it remains a largely unenforceable human right. The overarching reasons for this failure are numerous and include, among other things: (i) the difficulty in allocating scarce resources; (ii) disparities in health care delivery systems; (iii) the conceptual separation of end-of-life care from health care; (iv) a historic lack of consensus and training in the medical community regarding the core framework of end-of-life care; (v) the complexity in translating scientific evidence into policy and action; and finally, (vi) the absence of binding domestic legislation.

Palliative care aims to prevent and alleviate the pain and suffering of one of the world's most vulnerable groups–the dying. In 2002, the World Health Organization described palliative care as:

> an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.[2]

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[1] Margaret A Somerville, "Human Rights and Medicine: The Relief of Suffering" in Irwin Cotler & F Pearl Eliadis, eds, *International Human Rights Law: Theory and Practice* (Montréal: Canadian Human Rights Foundation, 1992) 505 at 506.

[2] World Health Organization, "WHO Definition of Palliative Care," online: WHO <www.who.int//cancer/palliative/definition/en/> [WHO, "Definition"] (Palliative care has also been described by the WHO as simply, "end-of-life" care, delivered to people at the last stages of life and in progressive decline). Palliative end-of-life care is also known as "hospice palliative care," that is, whole-person health care that "aims to relieve suffering and improve the quality of living and dying. Hospice palliative care strives to help patients and families address physical, psychological, social, spiritual and practical issues, and their associated expectations, needs, hopes, and fears; prepare for and manage self-determined life closure and the dying process; cope with loss and grief during the illness; and bereavement" (Canadian Hospice Palliative Care Association, "Hospice Palliative Care in Canada: A Brief to the Special Senate Committee on Aging" (Ottawa: CHPCA, 2007) at 2 [CHPCA, "Brief"]). The specific term "palliative care" emerged in the 1970s and is attributed to Canadian physician, surgeon, and academic, Balfour Mount (David Clark, "From Margins to Centre: A Review of the History of Palliative Care in Cancer" (2007) 8:5 The Lancet Oncology 430 at 434). See also Balfour Mount, "The Royal Victoria Palliative Care Service: A Canadian Experience" in

This definition reveals that palliative care embodies an integrated vision of health care, addressing more than just the physical symptoms of the patient experiencing the life-limiting illness.[3] It acknowledges the relationship between physical and mental suffering, each of which is "capable of affecting the other."[4] Thus, it is whole-person care, seeking to prevent and relieve the full spectrum of the individual's suffering and distress. It is also integrated care, the goal being to improve the individual's quality of living as well as their quality of dying.[5]

In this paper, the terms "palliative care," "hospice palliative care," "palliative end-of-life care," and "end-of-life care" are used interchangeably and in their broadest sense, meaning: whole-person health care aimed at relieving suffering and improving the quality of living and dying at the end of life. However, even though a number of definitions exist, there is among the health care providers "no common understanding of palliative care and end-of-life care and where each begins."[6]

For the past two decades, advocates in the field of palliative care have been diligently piecing together the linkages, justifications, and foundations for establishing a human right to palliative care.[7] The impetus to establish palliative care as a human right arises out of the reality that throughout the world, there

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Dame Cicely Saunders & Robert Kastenbaum, eds, *Hospice Care on the International Scene* (New York: Springer, 1997).

[3] Life-limiting illness can be described as a condition, illness, or disease that is eventually fatal, and the progress of which cannot be reversed by treatment. Life-limiting illness therefore includes "terminal" illness, "an illness in which, on the basis of the best available diagnostic criteria and in the light of available therapies, a reasonable estimation can be made prospectively and with a high probability that a person will die within a relatively short time" (Ronald Bayer et al, "The Care of the Terminally Ill: Morality and Economics" (1983) 309:24 New Eng J Med 1490 at 1491).

[4] Clark, *supra* note 2 at 431.

[5] CHPCA, "Brief", *supra* note 2.

[6] The Honourable Sharon Carstairs, *Raising the Bar: A Roadmap for the Future of Palliative Care in Canada* (Ottawa: Senate of Canada, 2010) at 24, online: Government of Canada <sen.parl.gc.ca/scarstairs/PalliativeCare/Raising%20the%20Bar%20June%202010%20(2).pdf> [Carstairs, *Raising the Bar*].

[7] The genesis of this discussion is attributed to Margaret Somerville, a medical-law scholar at McGill University in Montréal: Frank Brennan, "Palliative Care as an International Human Right" (2007) 33:5 Journal of Pain and Symptom Management 494 at 494 [Brennan, "Palliative Care as Right"]. See also Somerville, *supra* note 1.

exist "wide disparities in the capacity, resources and infrastructure" devoted to the care of those suffering from life-limiting illnesses.[8] Despite its expansive health care system, Canada is not immune to this issue. Within Canada, significant disparities with respect to access, quality, and delivery of palliative care also exist,[9] provoking the need–the objective of this paper–to specifically consider whether an enforceable human right to palliative care exists under Canadian law.

The sense of urgency with respect to these disparities has intensified as medical headway continues to be made in our understanding of the required content of palliative care. For example, as alluded to above, within the palliative care community, there is a growing consensus that an integrated approach[10] to the amelioration of pain and end-of-life distress must be taken into

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[8] Brennan, "Palliative Care as Right" *ibid* at 494. "In 2006, a detailed picture emerged from the first study to our knowledge ever to attempt an estimate of the global provision of palliative care. In total, 115 of the world's 234 countries have established one or more hospice–palliative care services. However, only 35 (15%) of the 234 countries have achieved a measure of integration with other mainstream service providers together with wider policy recognition. Such a picture must be set against the stark realities of global need: 56 million deaths per year, with an estimated 60% who could benefit from some form of palliative care. Current provision of palliative care reaches only a tiny proportion of these patients, and the solution lies in better palliative care within mainstream health-care systems" (Clark *supra* note 2 at 436, citing Michael Wright et al, *Mapping Levels of Palliative Care Development: A Global View* (Lancaster: International Observatory on End of Life Care, 2006)).

[9] The Honorable Sharon Carstairs, *Still Not There: Quality End-of-Life Care: A Progress Report* (Ottawa: Senate of Canada, 2005) at 1, online: Government of Canada <sen.parl.gc.ca/scarstairs/PalliativeCare/Still%20Not%20There%20June%202005.pdf> [Carstairs, *Still Not There*].

[10] A multi-disciplinary, integrated approach to end-of-life care encompasses "psychosocial, existential and spiritual aspects of the patient's experience" in addition to the technical aspects of symptom management. See Harvey Max Chochinov, "Dying, Dignity and New Horizons in Palliative End-of-Life Care" 56:2: CA: A Cancer Journal for Clinicians 84 at 84 [Chochinov, "New Horizons"]. Equally, the objective of palliative care is to enhance the patient's quality of life and provide support systems using a team approach to address the needs of the patient and the patient's family (WHO, *Definition*, *supra* note 2). For a similar view, expressed by Health Canada, see "Palliative and End-of-Life Care", online: Health Canada <www.hc-sc.gc.ca/index-eng.php>. See also S Robin Cohen et al, "Existential Well-Being is an Important Determinant of Quality of Life: Evidence from the McGill Quality of Life Questionnaire" (1996) 77:3 Cancer 576; Tom A

account in order to address the full spectrum of suffering, including the ascendant obligation of all health care, the dignity of the individual.[11] The fact that the Canadian population is aging also underscores the necessity of responding to these disparities. By 2031, it is expected that approximately 25% of the Canadian population will be 65 years of age or older, and that 6.1% to 6.5% of the Canadian population will be 80 years or older.[12] And although senior citizens account for 75% of Canadian deaths per year, only 1 in 7 Canadians over the age of 75 is likely to go into some form of institutional care.[13] The sense of urgency has become further heightened as many jurisdictions, including Canada, are currently debating the legalization of assisted suicide.[14] Dis-

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Hutchinson, Nora Hutchinson & Antonia Arnaert, "Whole Person Care: Encompassing the Two Faces of Medicine" (2009) 180:8 Canadian Medical Association Journal 845; L Marr, J Andrew Billings & David E Weissman, "Spirituality Training for Palliative Care Fellows" (2007) 10:1 Journal of Palliative Medicine 169; B Mount & M Kearney, "Healing and Palliative Care: Charting Our Way Forward" (2003) 17:8 Palliative Medicine 657.

[11] See generally Chochinov, "New Horizons" *ibid* at 84; Frank Brennan, "Dignity: A Unifying Concept for Palliative Care and Human Rights" [Brennan, "Dignity" on file with the *MJLH*]; Sylvia Patricia Duarte Enes, "An Exploration of Dignity in Palliative Care" (2003) 17:3 Palliative Medicine 263.

[12] Alain Bélanger et al, "Population Projections for Canada, Provinces and Territories: 2005-2031" at 50, online: Statistics Canada <www.statcan.gc.ca/pub/91-520-x/91-520-x2005001-eng.pdf>. See also Carstairs, *Raising the Bar*, *supra* note 6 (Seniors account for 75% of Canadian deaths per year and "almost 4 out of 5 people over the age of 65 have one chronic disease and about 70% have two or more progressive, life-limiting conditions" at 12-13).

[13] Carstairs, *Raising the Bar*, *ibid* at 12. See also Senate Committee on Aging, *First Interim Report: Embracing the Challenge of Aging* (Ottawa: Senate of Canada, 2007) at 68, online: <www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/agei-e/rep-e/repintfeb07-e.pdf>.

[14] In Canada, see e.g. Bill C-384, *An Act to amend the Criminal Code (right to die with dignity)*, 2nd Sess, 40th Parl, 2009 (defeated on second reading) as well as the more recent Québec hearings on euthanasia, assisted suicide, and dying with dignity commenced in September 2010. In South Australia, a recent private member's bill designed to allow voluntary euthanasia was tabled June 2010 but defeated at second reading (*Voluntary Euthanasia Bill 2010*, 23rd House of Assembly (first reading 24 June 2010), online: <www.legislation.sa.gov.au>). For recent UK developments, see especially *R (Purdy) v Director of Public Prosecutions*, [2009] UKHL 45, [2010] 1 AC 345. Prosecutorial guidelines regarding assisted suicide were changed as a result of this ruling: Director of Public Prosecutions, "Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide" (London:

parities raise a number of concerns here, including those related to the ability to provide patients with meaningful access and choice when seeking to alleviate their suffering and distress.[15]

At the international level, the main strategies for advancing palliative care as a human right have been to link palliative care to the more expressly recognized "right to health care," as either a subset or extension thereof; or to link it conceptually, given its mandate, to international conventions that recognize the "dignity of the person."[16] Under these strategies, key progress has been made in mobilizing and sustaining the commitment towards establishing palliative care as a human right. Notwithstanding this critical progress, however, there are limits to these approaches. Perhaps the best known of these is the common difficulty of all internationally-recognized human rights: enforcement. In Canada, the ability to enforce international treaty rights is entirely dependent on Canadian domestic law. With respect to international human rights, specifically, Canada has tended *not* to implement targeted legislation, but rather has confirmed its commitments on the basis of existing Canadian legislation, policies, administrative measures, and programs.[17] Thus, existing Canadian laws and norms, such as the *Canadian Charter of Rights and Freedoms*,[18] as well as other legislation, human rights codes, and policies must be canvassed in order

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Crown Prosecution Service, February 2010), online: CPS <www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html>.

[15] For further discussion see Mary J Shariff, "The Dying Need Proper Care Before We Settle Assisted Suicide" (2010) 30:13 The Lawyers Weekly 5 at 5. See also Carstairs, *Raising the Bar*, *supra* note 6 ("However, palliative care offers the opportunity to manage symptoms, and provide physical, emotional, and spiritual support to the dying. Along with many of my Senate colleagues, I became convinced that before we could have a debate about euthanasia and assisted suicide in Canada we should be providing equitable access to quality, integrated palliative care. As a Committee, we were unanimous in our belief that what was needed was better care for the dying - better pain control, better training, and more research." at 5); Mary J Shariff, "Navigating Assisted Death and End-of-Life Care" (2011) 183:6 Canadian Medical Association Journal 643 [Shariff, "Navigating Assisted Death"].

[16] See discussion in Part II of this paper, *infra*.

[17] See e.g. Elisabeth Eid & Hoori Hamboyan, "Implementation by Canada of its International Human Rights Treaty Obligations: Making Sense Out of the Nonsensical" in Oonagh E Fitzgerald, ed, *The Globalized Rule of Law: Relationships Between International and Domestic Law* (Toronto: Irwin Law, 2006) 449.

[18] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B of the *Canada Act 1982* (UK), 1982, c 11 [*Charter*].

to ascertain whether an enforceable human right to palliative care actually exists in Canada.[19]

Another obstacle to advancing integrated palliative care as a subset of health care, is the conceptualization of palliative care as specialized care or "boutique care,"[20] a perspective that continues today.[21] In Canada, this conceptualization is reflected in the structure of the *Canada Health Act*,[22] which distinguishes between services that are "insured" (medically "necessary" or "required" care) and services considered "extended."[23] As will be discussed later in this paper, palliative care generally falls into the latter category, meaning it does not attract federal support under the *CHA*.[24] Accordingly, with limited exceptions, responsibility for the delivery of palliative care falls mainly to the budgetary discretion of the provinces. Thus, palliative care delivery varies from province to province and the scope and quality of care lacks consistency.[25] Indeed, palliative care services are provided across a number of different settings, including via acute care, long-term care, or home care. While the majority of Canadians would prefer palliative home care–and indeed, to die at home–[26]this is currently not a realistic expectation because 75% of deaths occur in hospitals and long-term care facilities.[27] Furthermore, as a result of "long-term care" falling to provincial or territorial governance, long-term care itself is fragmented. As described by Health Canada,

> [a]cross the country, jurisdictions offer a different range of services and cost coverage. Consequently, there is little consistency across Canada in:

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[19] Eid & Hamboyan, *supra* note 17 at 455-456.

[20] Carstairs, *Still Not There*, *supra* note 9 at 13.

[21] Clark, *supra* note 2 at 433.

[22] *Canada Health Act*, RSC 1985, c C-6 [*CHA*].

[23] *Ibid* s 2.

[24] For more discussion see Part III.B of this paper.

[25] See *supra* note 7 and associated text. See also Canadian Institute for Health Information, *Health Care Use at the End of Life in Western Canada* (Ottawa: CIHI, 2007) at ch 3 and 5 [CIHI, *Western Canada*].

[26] World Health Organization, *The Solid Facts: Palliative Care* (Copenhagen: WHO Regional Office for Europe, 2004) at 16, online: <www.euro.who.int/__data/assets/pdf_file/0003/98418/E82931.pdf> [WHO, *Solid Facts*].

[27] CIHI, *Western Canada*, *supra* note 25 at 40.

- what facilities are called (e.g. nursing home, personal care facility, residential continuing care facility, etc.);
- the level or type of care offered and how it is measured; and
- how facilities are governed or who owns them.[28]

The harsh reality is that 70% or more of Canadians currently do not have access to palliative care.[29] While part of this figure is attributable to the overarching jurisdictional issues, as described above, it is also attributable in part to a number of other critical factors, including: geographic remoteness;[30] ongoing institutional restructuring;[31] eligibility requirements;[32] federal jurisdiction over particular groups;[33] and point-of-entry into the health care system.[34]

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[28] Health Canada, "Long-Term Facilities-Based Care", online: <www.hc-sc.gc.ca/hcs-sss/home-domicile/longdur/index-eng.php>.

[29] Carstairs, *Raising the Bar*, *supra* note 6 at 12.

[30] According to the Canadian Hospice Palliative Care Association, access to hospice palliative care services by Canadians living in remote/rural areas and those with disabilities is severely limited: CHPCA, "Hospice Palliative Care in Canada" (Ottawa, CHPCA 2004) online: <www.chpca.net/uploads/files/english/resource_doc_library/Fact_Sheet_HPC_in_Canada.pdf> [CHPCA, "Fact Sheet"]

[31] Health care restructuring has reduced institutional care with more reliance on community-based agencies but with no proportionate increase in funding to these agencies. See CHPCA, "Fact Sheet," *ibid* .

[32] "Eligibility [for] home palliative/end-of-life care often requires a physician referral and a prognosis of death within a set time frame, usually six months. In some jurisdictions, clients must declare that they are no longer seeking curative treatment" (Health Council of Canada, *Home Care: A Background Paper* (Toronto: HCC, 2005) at 9 online: HCC <www.healthcouncilcanada.ca/docs/papers/2005/BkgrdHomecareENG.pdf>).

[33] See discussion in Carstairs, *Still Not There*, *supra* note 9 at 31-37 (For example, the federal government is responsible for delivery of health care, including palliative care, to: members of First Nations and Inuit communities, Canadian Forces personnel, veterans, members of the Royal Canadian Mounted Police, inmates in federal penitentiaries, and refugee claimants. Thus, access to palliative care can simply be a function of status or entitlement rather than need. That being said, accessibility of care is still not guaranteed, and it appears that it is only in the case of veterans that there is any semblance of coordinated palliative care services).

Furthermore, under a 2009 directive, federal inmates suffering from a terminal or chronic illnesses may be eligible for parole. While this is presumably aimed at providing an opportunity for release on compassionate grounds, it also can be seen

The bottom line is that most Canadians do not have access to palliative care; of those who do, the delivery and content of that care is inconsistent. In 2004 the "10-year Plan to Strengthen Canada" was published.[35] In the 10-year Plan, the First Ministers made certain commitments towards improving access to quality care for all Canadians. Many of these commitments directly impact end-of-life care and include: improving access to services based on need; first dollar support for home care services including "end-of-life care for case management, nursing, palliative-specific pharmaceuticals and personal care at the end of life"; and medical transportation for those who live in remote northern communities.[36] While the 10-year Plan is undoubtedly a step in the right direction, it really amounts to an increased federal role in funding provincial and territorial health care expenditures, leaving the Achilles heel of palliative care intact–that is, dependence on provincial/territorial discretion and the resulting variations in access, delivery, and content of palliative care.

This paper sets out to challenge the ongoing disparity by exploring the foundations for an argument for an enforceable human right to palliative care in Canada under the *Charter*. The objective of this paper is not to craft comprehensive *Charter* arguments. Rather, the main objective is to provide a starting point for discussion on a human right to palliative care in Canadian law.

Part I of this paper provides an overview of the international instruments being advanced to establish a human right to palliative care. In particular, the limitations of the international approach are more fully explored, particularly with respect to domestic enforcement. The section also includes an in-depth investigation of the concept of "dignity" as a potential means for advancing a right to palliative care, again exploring its weaknesses or limitations. In Part II we turn specifically to domestic Canadian law, especially the *Charter*, explor-

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to promote early release in lieu of providing long-term palliative care within the federal prison system (Correctional Service of Canada, "Health Services" Commissioner's Directive No 800 (Ottawa: CSC, 2009) at ss 1, 44-45, online: CSC <www.csc-scc.gc.ca/text/plcy/cdshtm/800-cde-eng.shtml>). For an introduction to this topic see Joseph O'Neill, Mohammad Akhter & Lucie Poliquin, "Terminally Ill Offenders: An International Dialogue" (2002) 9 Journal of Correctional Health Care 119.

[34] Discussed further in Parts III.C and III.D below.

[35] Health Canada, "A 10-year plan to strengthen Health Care" (2004), online: Health Canada <www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php> [Health Canada, "10-year Plan"].

[36] *Ibid*. For discussion of additional initiatives and achievements that have been taken over the past number of years, see summary in Carstairs, *Raising the Bar*, *supra* note 6 at 15.

ing the grounds on which an enforceable right to palliative care might be established in Canada. After an overview of the *Canada Health Act*, the paper suggests that sections 7 and 15 of the *Charter* potentially provide a starting point for articulating an enforceable right to palliative care in Canada. In Part III, some limits of a *Charter* approach are addressed. The first of these is the internal limit on *Charter* rights, namely, justification under section 1. The second is an evidentiary limit to the establishment of a Canadian constitutional right to palliative care.

In the view of the authors, while research has clearly identified a need for integrated palliative end-of-life care in Canada, some of the critical elements needed to establish a constitutional right to palliative care still need to be supported by further study. Accordingly, the critical points to be taken from the discussion that follows are:

- *without* the domestic legal tools to enforce a right, a human right, such as palliative care, is largely illusory; and
- in the process of seeking out and applying the domestic legal tools to address perceived injustices, the scope of the right in question becomes better delineated, which in turn serves to illuminate the paths to legislative reform.

While not all countries have a constitutionally-entrenched *Charter*, as we do in Canada, we hope that from the discussion that follows, further paths and directions may emerge that will be of assistance in identifying palliative care as a legally-enforceable human right both in Canada and internationally.

I. Understanding the Limitations of International Human Rights Instruments

A. Palliative Care and the International Human Rights to Security, Equality, and Health

Human rights encompass the full range of standards derived from the United Nations *Universal Declaration of Human Rights*.[37] These rights are formalized in many international legal instruments, including covenants to which Canada is a signatory.[38] As described earlier, however, in order for in-

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[37] *Universal Declaration of Human Rights*, GA Res 217(III), UN GAOR, 3d Sess, Supp No 13, UN Doc A/810 (1948) 71 [*UDHR*].

[38] *The International Covenant on Civil and Political Rights*, 19 December 1966, 999 UNTS 171 arts 2-21, Can TS 1976 No 47, 6 ILM 368 (entered into force 23 March 1976, accession by Canada 19 May 1976) [*ICCPR*]; *UDHR*, *ibid*. Political

ternational agreements to be binding within Canada, they have to be enshrined in domestic law either by statute or common law.[39] In other words, domestic law cannot be interpreted in such a way as to violate international commitments unless the domestic law at issue expressly requires that consequence.[40]

There is no express human right to palliative care in any UN treaty.[41] The World Health Organization (WHO), however, maintains that: "[a]ll people have a *right* to receive *high-quality care during serious illness* and to a *dignified death* free of overwhelming pain and in line with spiritual and religious needs."[42] The WHO points to the *UDHR*, in particular Article 25 thereof, to support this statement. Article 25 of the *UDHR* reads as follows:

> Everyone has the *right to … security* in the event of unemployment, *sickness, disability,* widowhood, *old age* or other lack of livelihood in circumstances beyond his [or her] control.[43]

Article 1 of the *UDHR* has also been identified as relevant to establishing palliative care as a human right. Article 1 reads:

> All human beings are born *free and equal in dignity and rights*. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.[44]

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and civil rights, including rights to: liberty and security; equality before and under the law; freedom of expression, conscience, and movement; and freedom from mistreatment and arbitrary detention, are all reflected by arts 3, 9-10, 13, 19 of the *UDHR* and are incorporated into *ICCPR*. Economic, social, and cultural rights including rights to: economic and social security; work and adequate standard of living; health; education; and leisure are reflected in arts 22-27 of the *UDHR* and are incorporated into the *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 UNTS 3, (entered into force 3 January 1976) [*ICESCR*].

[39] *R v Hape*, 2007 SCC 26, [2007] 2 SCR 292.

[40] See generally Gerald Heckman "The Role of International Human Rights Norms in Administrative Law" in Colleen M Flood & Lorne Sossin, eds, *Administrative Law in Context* (Toronto: Edmond Montgomery, 2008) 318.

[41] See Brennan, "Palliative Care as Right" *supra* note 7 at 495. Compare Liz Gwyther, Frank Brennan & Richard Harding, "Advancing Palliative Care as a Human Right" (2009) 38 Journal of Pain and Symptom Management 767 at 769-770 [Gwyther, Brennan & Harding, "Advancing Palliative Care"].

[42] WHO, *Solid Facts*, *supra* note 26 at 16 [emphasis added].

[43] *UDHR*, *supra* note 37 art 25 [emphasis added].

[44] *Ibid* [emphasis added]. See also *ibid* art 25.1 which states: "Everyone has the right to a standard of living adequate for the health of himself and of his family … "

The WHO underscores that the notions of fairness, equality, and equity in the *UDHR* require that established standards of palliative care (such as those developed for cancer care) be offered to all people with similar health needs.[45]

In addition to the *UDHR*, a human right to palliative care has also been argued to be a component or subset of an overall international human right to health.[46] For example, the *ICESCR* states:

> 12(1) The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the *highest attainable standard* of physical and mental health;
>
> 12(2) The steps to be taken by the States Parties to … achieve the *full realization* of this right shall include those necessary for:
>
> …
>
> (d) The creation of conditions *which would assure to all* medical service and medical attention in the event of sickness.[47]

In a General Comment, the UN Committee on Economic, Social and Cultural Rights–the body responsible for supervising government compliance with the *ICESCR*–included palliative care as part of states' obligation to respect the right to health. It did so by describing how states must refrain from, among other things, denying or limiting equal access to palliative health services.[48]

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[45] WHO, *Solid Facts*, *supra* note 26 at 16.

[46] See Brennan, "Palliative Care as Right" *supra* note 7 at 495. See also Council of Europe, Committee of Ministers, *Recommendation on the organisation of palliative care*, REC (2003) 24 (which stated *inter alia*, that palliative care is "an inalienable element of a citizen's right to health care" at 2); Senate, Subcommittee to Update *Of Life and Death*, *Quality End-of-Life Care: The Right Of Every Canadian* (Ottawa: Senate of Canada, 2000) online: <www.parl.gc.ca/36/2/parlbus/commbus/senate/Com-e/upda-e/rep-e/repfinjun00-e.htm> [*2000 Senate Report*] (recommending that end-of-life care should emerge from the current health care restructuring as a "core service available to all Canadians" at 5.C).

[47] *ICESCR*, *supra* note 38 art 12 [emphasis added].

[48] General Comment No 14 issued by the Committee of the *ICESCR* states: "In particular, States are under the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventative, curative and palliative health services" (Committee on Economic, Social and Cultural Rights, *General Comment 14: The right to the highest attainable standard of health*, ESC, 22nd Sess, UN Doc E/C.12/2000/4, (2000) at para 34 [empha-

There are also a number of specialized or regional covenants and treaties that contain provisions that may further strengthen the right to palliative care as a subset of the right to health care. Examples of instruments that mandate equitable access to available health care services include instruments with respect to the rights of the child,[49] racial discrimination,[50] and discrimination against women.[51] For the groups covered by these instruments, it may be possible to argue that the equitable right to health care *necessarily includes* certain positive rights related to palliative care.

The assertion of a positive right to palliative care under these international instruments, however, is highly problematic because of an overall lack of legal tools for enforcement. This seems to be the case notwithstanding the emergent global consensus about the precise content of a government's obligations with respect to palliative care (such as equitable access to and delivery of palliative care as a core component of health care[52]). While international instruments assist with documenting human rights violations and establish avenues for complaints to the governing human rights body, these review-type options do not

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sis in the original]). See also Gwyther, Brennan & Harding, "Advancing Palliative Care," *supra* note 41.

[49] *Convention on the Rights of the Child*, GA Res 44/45, UN GAOR, 44th Sess, Supp No 49, UN Doc A/44/49 (1989) 167 art 24.

[50] See *The International Convention on the Elimination of All Forms of Racial Discrimination*, GA Res 2106 (XX), UN GAOR, 21 December 1965, 660 UNTS 195 art 5(e)(iv) [I*CERD*].

[51] *Convention on the Elimination of All Forms of Discrimination against Women*, 18 December 1979, 1249 UNTS 13 arts 11.1(f), 12, Can TS 1982 no 31 (entered into force 3 September 1981) [*CEDAW*]. For an in-depth discussion see Frank Brennan, Liz Gwyther & Richard Harding, "Palliative Care as a Human Right" (Open Society Institute Public Health Program, 2008) at 23-26, online: <www.soros.org/initiatives/health/focus/ipci/articles_publications/publications/pchumanright_20080101> [Brennan, Gwyther & Harding, "Palliative Care as a Human Right"]. See also Liz Gwyther, Jonathan Cohen & Tamar Ezer, "Introduction to Human Rights and Palliative Care" in *Legal Aspects of Palliative Care* (Pinelands: Hospice Palliative Care Association of South Africa, 2009) at 7, online: < www.lrc.org.za/booklets/1014-2009-legal-aspects-of-palliative-care >.

[52] Committee on Economic, Social and Cultural Rights, *supra* note 47 at para 19. The *Declaration* comments on a right to health as one of the "core obligations" regardless of resource availability. See also Gwyther, Brennan & Harding, "Advancing Palliative Care," *supra* note 41.

provide the means to enforce governmental obligations, should the government fail to carry them out.[53]

Furthermore, as expressly acknowledged in the *ICESCR*, the ability to realize rights, including the right to health care, is ultimately dependent on the availability of resources, which varies from jurisdiction to jurisdiction.[54] Under the *ICESCR*, for example, government compliance with the right to health is "aspirational" only, and rights are to be achieved over time, based on the resource availability of respective signatory nations.[55]

Even if one were able to successfully argue that the *ICESCR*–or any other international instrument, for that matter–guaranteed a right to health care and therefore a right to palliative care, the *Charter*, as mentioned earlier, does not expressly guarantee a right to health care. Thus, the Canadian government is unlikely to recognize any right to health care, palliative care included, unless it has been grounded somewhere in Canadian domestic law.

B. Palliative Care and the International Human Right to Dignity

> While … every human rights violation involves a violation of human dignity, I do not agree that every violation of human dignity involves a violation of human rights.[56]

The notion of "dignity,"[57] a critically important and powerful cornerstone of palliative care,[58] has also been asserted as a potential legal foundation for

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[53] For further discussion, see the Ontario, Ministry of the Attorney General, *The Protection of Social and Economic Rights: A Comparative Study* (Toronto: MAG, 1991).

[54] *ICESCR*, *supra* note 38 art 2(1), 2(3).

[55] See Brennan, Gwyther & Harding, "Palliative Care as a Human Right," *supra* note 51 at 22-23.

[56] Brian Orend, *Human Rights: Concept and Context* (Peterborough: Broadview Press, 2002) at 88. For further discussion on difficulty in connecting dignity as an intrinsic right to a human right see Brennan, "Dignity," *supra* note 11. See also Brennan, Gwyther & Harding, "Palliative Care as a Human Right," *ibid* at 19-35.

[57] For a definition of dignity see *Québec (Public Curator) v Syndicat national des employés de l'hôpital St-Ferdinand*, [1996] 3 SCR 211 at 256, L'Heureux-Dubé J (referring to dignity in s 4 of the Québec *Charter* she writes "I believe that section 4 of the Charter addresses interferences with the fundamental attributes of a human being which violate the respect to which every person is entitled simply because he or she is a human being and the respect that a person owes to himself or

establishing a human right to health care.[59] Indeed, clinical palliative care models and international human rights instruments share the language of "dignity." Thus, dignity appears to provide a logical conduit for establishing palliative care as a human right. However, to assert dignity as the foundation for a legally-enforceable human right to palliative care requires that the term be capable of legal interpretation and definition. Despite the fact that the term dignity is cited in a number of human-rights proclamations,[60] including the *UDHR*,[61] these instruments provide no definition of dignity, nor has dignity been "authoritatively interpreted or applied by any of the competent, inde-

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herself" interestingly, the Québec *Charter* has a specific section referring to "dignity" as a right–in contrast to the Canadian *Charter*).

See also Dr Gro Harlem Brundtland, former Director-General of the World Health Organization, "Health, Dignity and Human Rights" (Keynote address at 7th Conference of European Health Ministers in Oslo, Norway, 12 June 2003), online: World Health Organization <www.who.int/dg/brundtland/speeches/2003/conference_european_healthministers/en/> (she states "at the root of the concern for equality and freedom from discrimination in human rights thinking and practice, lies the notion of human dignity: the equal and inherent value of every human being."). See e.g. *UDHR*, *supra* note 37 at Preamble. Accord *ICESCR*, *supra* note 38 at Preamble; *ICCPR*, *supra* note 38 at Preamble; I*CERD*, *supra* note 50 at Preamble; *CEDAW*, *supra* note 51 at Preamble. Many of the international human rights instruments explicitly state that the respective right described therein is derived from the inherent dignity of the human person.

[58] See generally David Morrison, "The Protection and Promotion of Human Rights and Dignity for Cancer Patients: An IPOS Responsibility" (Presidential Symposium on Psycho-Oncology and Palliative Care as a Human Right, delivered at the IPOS 11th World Congress of Psycho-Oncology, Vienna, 25 June 2009), online: <www.strathmor.com/assets/pdf/0906-PresidentialSymposium.pdf>; Harvey Max Chochinov, "Dignity and the Essence of Medicine: The A, B, C and D of Dignity Conserving Care" (2007) 334 Brit Med J 184 [Chochinov, "Dignity, Essence of Medicine"].

[59] See Brennan, "Dignity" *supra* note 11. See also Council of Europe, PA, 1999 Ordinary Sess (Third Part), *Protection of the Human Rights and Dignity of the Terminally Ill and the Dying*, Texts Adopted Rec 1418, V/99 Gazette Parliamentary Assembly 11 (s 1 of this document states: "The vocation of the Council of Europe is to protect the dignity of all human beings and the rights which stem therefrom"; s 5 states: "The obligation to respect and to protect the dignity of a terminally ill or dying person derives from the inviolability of human dignity in all stages of life").

[60] See discussion in Brennan, Gwyther & Harding, "Palliative Care as a Human Right," *supra* note 1 at 34.

[61] See *UDHR*, *supra* note 37 art 1.

pendent, international institutions."[62] The law has not defined dignity; hence, dignity is rooted "outside the jurisprudence"[63] and, as described by Morrison, is, simply, "pre-legal."[64] As will be clarified below, despite the fact that there are no legally binding definitions of "human dignity" in the jurisprudence, there is no doubt that the concept has played a key role in Canadian constitutional law, as laid down by the Supreme Court of Canada in the late 20th century. While the Court has recently stepped away from using this concept as definitive, this is a relatively recent development. Only the passage of time will tell us whether or not this constitutes a permanent shift in emphasis.

Additionally, it is important to note that the *Charter* does not explicitly mention "dignity"[65] and, furthermore, that the Supreme Court of Canada no longer requires a claimant to show an affront to dignity in order to prove infringement of the *Charter*'s equality provision.[66] According to the Supreme Court, dignity had "proven to be an *additional* burden on equality claimants, rather than the philosophical enhancement it was intended to be."[67] While it might be said that dignity forms part of the essence of the *Charter*, it is, for the

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[62] Bartha Maria Knoppers, *Human Dignity and Genetic Heritage: A Study Paper Prepared for the Law Reform Commission of Canada Protection of Life Series* (Ottawa: Law Reform Commission, 1991) at 23; see also Brennan, "Dignity," *supra* note 11.

[63] Morrison, *supra* note 58 at 2.

[64] *Ibid* at 2.

[65] While it is no longer a required element for proving a violation of equality rights under s 15 of the *Charter*, the notion of dignity is considered to be subsumed into the express *Charter* guarantees. See the discussion of dignity in *Rodriguez v British Columbia (AG)*, [1993] 3 SCR 519 (in both the majority reasons of Sopinka J and the dissenting reasons of McLachlin J). See also *Bou Malhab v Diffusion Métromédia*, 2011 SCC 9 ("Since good reputation is related to dignity, it is also tied to the rights protected by the *Canadian Charter*" at para 18).

[66] *R v Kapp*, 2009 SCC 41, [2008] 2 SCR 483 [*Kapp*]. See also Mary C Hurley, "Charter Equality Rights: Interpretation of Section 15 in Supreme Court of Canada Decisions" (Ottawa: Library of Parliament, 2007) online: <www.parl.gc.ca/information/library/PRBpubs/bp402-e.htm> ("The claimant's burden of establishing section 15 infringement does not oblige her or him to adduce evidence of violation of human dignity or freedom; the fact that a distinction in treatment is based on one or more section 15 grounds will often be sufficient to establish such an infringement in that it will be apparent, through judicial notice and logic, that the distinction is discriminatory" at 8).

[67] *Kapp*, *ibid* at para 22, McLachlin CJC & Abella J [emphasis in original].

above reasons, not an efficient means to advance a legal right to palliative care under the *Charter*.[68]

That being said, dignity is used in many international human rights instruments, and the Supreme Court has mandated that Canadian courts should, in making their decisions, take these instruments into account when Canada is a signatory.[69] This is the case even when these instruments have not yet been given the full force of law domestically.[70]

As described by the Supreme Court in *Baker v Canada*:

> the values reflected in international human rights law may help inform the contextual approach to statutory interpretation and review.[71]

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[68] In its preamble, the *Canadian Bill of Rights*, SC 1960, c 44, reprinted in RSC 1985, App III, states that the Parliament of Canada affirms that "the Canadian Nation is founded upon principles that acknowledge the supremacy of God, the dignity and worth of the human person and the position of the family in a society of free men and free institutions." Therefore, the *Bill of Rights* might be used to support arguments that dignity is a right, and that dignity includes the right to health care which in turn includes a right to end-of-life care. Indeed, the federal Senate Committee in its 2000 report on end-of-life care points to the *Bill of Rights* to assert that human dignity and worth "compel" the provision of excellent end-of-life care (*2000 Senate Report*, *supra* note 46 at 5). Yet reliance on the *Bill of Rights* to assert a right to palliative care is problematic for a number of reasons, too numerous to be fully canvassed herein. Perhaps the most relevant of these for this paper is that the *Bill of Rights* applies only to the federal government, while delivery of health care is mainly within provincial jurisdiction, and thus not subject to the *Bill of Rights*. For further discussion see Peter W Hogg, *Constitutional Law* (Toronto: Carswell Legal, 2010) at ch 34.3(b), ch 35.

[69] The terms of the rights covenants (and any decisions rendered under them by an international human-rights committee) are relevant to interpretation of the *Charter* pursuant to a principle that statutes should be interpreted in conformity with international law as far as is possible. For further discussion see Ruth Sullivan, *Sullivan on the Construction of Statutes*, 5th ed (Markham: LexisNexis Canada, 2008) at 537-549.

[70] See *Health Services and Support – Facilities Subsector Bargaining Association v British Columbia*, 2007 SCC 27 at paras 20, 69, [2007] 2 SCR 391, 283 DLR (4th) 40. See also *Baker v Canada (Minister of Citizenship and Immigration)*, [1999] 2 SCR 817 at 860-862, 174 DLR (4th) 193 [*Baker*]; *Slaight Communications v Davidson*, [1989] 1 SCR 1038 at 1056-1057, 59 DLR (4th) 416 [*Slaight Communications*].

[71] *Baker*, *ibid* at 861.

Again, however, the term "dignity," even when articulated by ratified international instruments, is simply neither legally rigorous enough, nor, arguably, required to support a constitutional right to palliative care in Canada. This is not to say that dignity is wholly irrelevant, particularly given Canada's international commitments, including those in the "International Bill of Rights."[72] But dignity itself (or an affront to dignity) does not justify or establish a legally-enforceable right to palliative care. It is therefore asserted herein that advancing a right to palliative care on the basis of the concept of dignity is not required in Canada.[73]

Furthermore, while the *ICCPR*, for example, contemplates rights similar to those of the *Charter*, a protocol to the *ICCPR*, of which Canada is a party, requires that individuals claiming a violation of rights under the protocol first exhaust all available domestic remedies before petitioning the Human Rights Committee of the United Nations.[74] Thus, the *Charter* is necessarily where we begin our substantive discussion.

II. Potential *Charter* Arguments

A. Overview

The authors have identified two possible approaches that may help to establish a legally enforceable human right to palliative care under the *Charter*.[75] A first approach attempts to establish that there is indeed a legal right to health

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[72] *UNDHR*, *supra* note 37 at Preamble, arts 1, 22 ; *ICCPR*, *supra* note 38 at Preamble, art 10(1); *ICESCR*, *supra* note 38 at Preamble. The *UDHR*, *ICCPR* and *ICESCR* together are understood as "The International Bill of Human Rights."

[73] The authors however should not be understood as in any way dismissing the significance of "dignity" in conceptualizing the substance of palliative care (and health care generally) or the critical importance of approaches aimed at elucidating the potential of dignity in advancing a human right to palliative care.

[74] *ICCPR*, *supra* note 38 at art 41(c); *Optional Protocol to International Covenant on Civil and Political Rights*, 16 December 1966, 999 UNTS 302 at art 2 (entered into force 23 March 1976, accession by Canada 19 May 1976). For further discussion see Hogg, *Constitutional Law*, *supra* note 68 at ch 36.9(c). In addition, the signatory government must also be a signatory to the protocol in order for such petition to be made.

[75] It is important to reiterate that the review provided here is not intended to be comprehensive. While there are additional initiatives being undertaken at the federal and provincial levels to increase and support palliative and end-of-life care, (see e.g. the 10-year Plan *supra* note 35) the focus of this review is to establish some foundation for an argument in favour of a *constitutional right* to palliative care.

care in Canada, which includes palliative care in the provision of core health care services, by arguing that the omission of palliative care constitutes a breach of section 7 *Charter* guarantees.

A second approach offers a more direct path, in that it does not rely on having to first establish a legal right to health care. Rather, this second approach involves only the consideration of how existing health care legislation pertaining to palliative care operates to violate section 15 *Charter* guarantees. There is no positive right to a minimum standard of health care in Canada (this is discussed in more detail below); thus, the argument required to establish a constitutional right to palliative care under the second approach must demonstrate either that there is an violation of *Charter* rights in the delivery of extended care, or that certain distinctions between insured care and non-insured (i.e. extended) care made in the *CHA* are in violation of *Charter* rights.

In either case, the authors suggest that there are certain *Charter* rights and principles that can support a right to palliative care under Canadian constitutional law.[76] Again, the goal here is not to set out detailed *Charter* arguments. Rather, the authors wish to encourage the discourse to develop these complex arguments by illuminating *Charter* rights and cases relevant to the delivery of palliative care in Canada. These rights and cases can, in turn, be used to challenge legislation and policies that appear to thwart equal and meaningful access to quality end-of-life care. As written by the late Tommy Douglas, former premier of Saskatchewan and champion of public health care:

> When we began to plan Medicare, we pointed out that it would be in two phases. The first phase would be to remove the financial barrier between those giving the service and those receiving it. The second phase would be to reorganize and revamp the delivery system–and, of course, that's the big item; it's the big thing we haven't done yet.[77]

According to the authors, this second phase should include the realization of palliative end-of-life care as an enforceable right.

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[76] In the pages that immediately follow, the authors' focus primarily on the second argument because of the availability of empirical evidence that can be used to support such an argument. This is not to say that the first argument is without merit. This is explored to a certain extent (given the empirical limitations) under the heading "Care versus Cure" in Part III.D(4) below.

[77] Interview of Michael B Decter, former Deputy Minister of Heath, The Atkinson Letter (10 January 1997) online: Atkinson Foundation <www.atkinsonfoundation .ca/publications/health4.htm> (Decter cites Tommy Douglas' writings).

B. The Canada Health Act

Before we can consider *Charter* arguments, we must first determine whether there is a right to accessible health care in Canada, and, if so, the scope of that right. Put another way, what is the nature of the legislative framework securing the legal right to health care in Canada? As Sharon Sholzberg-Gray, former president of the Canadian Healthcare Association, wrote:

> Universal access to needed healthcare services is regarded as a core value of Canadians and a measure of equality of citizenship. In Canada, we have done much more than simply talk about the idea that accessibility to healthcare is a public good; we have made it the law of the land.[78]

The *CHA* is the foundation of the publicly funded health care system in Canada.[79] According to the *CHA*, the primary objective of Canadian health policy is:

> to protect, promote and restore the physical and mental well-being of residents in Canada and to *facilitate reasonable access* to health services without financial or other barriers.[80]

The phrase "facilitate reasonable access" is important. It is *not* the object of the *CHA* to establish a positive right to a minimal standard of health care, except to the extent that care, as a service, is considered medically required or necessary (as discussed below). Indeed, the function of the *CHA* is to establish the criteria and conditions that must be met by the provinces and territories in order to qualify for the federal cash contribution under the Canada Health and Social Transfer.[81] To this end, the *CHA*'s main objective is to ensure that all eligible residents of Canada have reasonable access to quality health care–that is, without financial or other barriers.[82]

Not all health care, however, is covered. As mentioned above, the *CHA* distinguishes between insured health services and what are described as "ex-

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[78] Sharon Sholzberg-Gray, "Accessible Health Care as a Human Right" (1999/2000) 11:2 NJCL 273 at 274.

[79] *CHA*, *supra* note 22. The *CHA* was passed in 1984, replacing the *Hospital Insurance and Diagnostic Services Act*, RSC 1957, c 28 and the *Medical Care Act*, RSC 1970, c M-8.

[80] *CHA*, *ibid* s 3 [emphasis added].

[81] *Ibid* ss 4-7.

[82] *Ibid* s 3.

tended" services. Only insured health services are subject to the "reasonable accessibility" criteria.[83] These services are further subject to the additional four criteria of public administration,[84] comprehensiveness,[85] universality,[86] and portability,[87] which, together, comprise what are known as the "five principles" of the *CHA*. These criteria (along with two conditions)[88] must be met by the provinces and territories in order for them to qualify for federal funding.[89]

Accordingly, under the *CHA* there is a right to insured health services and reasonable access to those services, but not to extended services. Insured health services include hospital services, physician services, and surgical-dental services provided to insured persons.[90] In all cases, insured services are those considered medically "necessary" or "required."[91] Despite the importance of these words, in terms of identifying those services that are subject to the five principles, the statute does not specifically define them. The result has been that medically required physician services "are generally determined

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[83] *Ibid* s 12 (which states that provinces must provide insured persons with uniform and reasonable access to insured health services).

[84] *Ibid* s 8 (sets out that provincial health care insurance plans must be administered and operated on a non-profit basis by a public authority).

[85] *Ibid* s 9 (which stipulates that provincial plans must insure all insured health services provided by hospitals, medical practitioners or dentists).

[86] *Ibid* s 10 (which demands that all residents in the province have access to insured services on uniform terms and conditions).

[87] *Ibid* s 11 (which requires that provinces pay for insured health services for residents -typically persons who have lived in the province for three months or longer- when temporarily absent from the province or Canada as well as pay amounts for insured health services provided in another province).

[88] *Ibid* s 13 (under s 13, the provincial governments are required provide any information required by the Minister and give recognition to any federal transfers in their respective public and promotional documents).

[89] *Ibid* s 7.

[90] *Ibid* s 2 ("'insured health services' means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation.")

[91] *Ibid* s 2 (the interpretation section of the *CHA*, and in particular the definitions of "health care insurance plan," "hospital services," "insured health services," and "surgical-dental service").

by physicians in conjunction with their provincial and territorial health insurance plans."[92]

Extended health services are described in the *CHA* as services including: (i) nursing home intermediate care; (ii) adult residential care service; (iii) home care service; and (iv) ambulatory health care service.[93] Although the *CHA* refers to regulations that are supposed to assist in specifically defining "extended health care services," no such regulation has yet been created by the federal government.[94] Extended health services therefore tend to encompass a broader "continuum of care" (which includes services such as access to pharmaceuticals outside of the hospital setting, home and community care, long-term care, and palliative care) and are generally not considered medically "necessary" or "required."[95] Thus, these services are not protected under the *CHA*'s five principles and the *CHA* does not require the provinces and territories to provide funding for these extended services. Instead, it is up to the individual provincial and territorial governments to determine whether and how they will fund extended care.[96] Only "the four western provinces ... have designated palliative care as a [provincial] core service," while the remaining six provinces and the three territories have not yet done so.[97]

The delivery, accessibility, and content of palliative end-of-life care are thus a function of provincial and territorial discretion, and, as described above, significant disparities exist across Canada. Under this framework, the dispari-

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[92] Health Canada, *Canada Health Act: Annual Report 2008-2009* (Ottawa: Health Canada) at 3 online: Health Canada <www.hc-sc.gc.ca/hcs-sss/alt_formats/pdf/pubs/cha-ics/2209-cha-ics-ar-ra/chaar-ralcs-09-eng.pdf >.

[93] *CHA*, *supra* note 22 at s 2.

[94] See *ibid*, s 2 definition of "extended health care services".

[95] See Sholzberg-Gray, *supra* note 78 at 284. For a description of medically necessary see *Auton (Guardian ad litem of) v British Columbia (AG)*, 2002 BCCA 538 at paras 36-40, 220 DLR (4th) 411. The Court of Appeal's judgment would be reversed on other grounds, 2004 SCC 78, [2004] 3 SCR 657, 245 DLR (4th) 1 [*Auton* cited to SCR].

[96] *Auton*, *ibid*, McLachlin CJC ("… the medicare scheme … envisions … core physician-provided benefits plus non-core benefits at the discretion of the Province" at paras 43-44).

[97] See the Honourable Sharon Carstairs, "Motion Urging Government to Provide Long-term End-of-life Care" in Debates of the Senate (Hansard), 39th Parl, 1st Sess, No 143:5 (25 April 2006) at 84 [Carstairs, "Motion"].

ties only stand to increase, given shifting demographics[98] and increased demand by an expanding and aging population.[99]

C. Section 15

Having described the general regulatory framework that establishes palliative care as extended care, as well as having provided certain facts and data to illustrate that disparities in the delivery of palliative care exist in Canada, the discussion now turns expressly to the *Charter*, commencing with section 15. This discussion begins by looking at one example that readily illustrates the inequalities of access to palliative care–namely, cancer care. The authors acknowledge and applaud the efforts of pioneers of palliative care, many of whom were and still are focused primarily on cancer care. The question here, however, is not whether noble and valuable work has been done in cancer care; indeed, the authors want to make it clear that this work is not being criticized. The issue of concern to the authors is whether a constitutional argument can be made to support palliative care as an enforceable right in Canada based on the unequal provision of palliative care to patients who are not suffering from cancer. These legal arguments are not aimed at diminishing care for cancer patients or the work of those employed in this crucial field.

The purpose of this Part is to establish at least *some* of the factual bases that might be used to assert a breach of rights under section 15 of the *Charter*. Once this factual foundation has been laid, we turn to relevant *Charter* cases and set out some of the arguments that may help to establish an enforceable right to care, with the caveat that further empirical evidence is essential to founding a strong *Charter* argument.

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[98] See text accompanying note 13, *supra*. See also Senate, Special Senate Committee on Aging, *Canada's Aging Population: Seizing the Opportunity* (Ottawa: Senate of Canada, 2009) at 5 (Chair: Hon Sharon Carstairs) [Senate, *Canada's Aging Population*]; Canada, *Commission on the Future of Health Care, Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa: Government of Canada Publications, 2002) at 20-23, online: Depository Services Program <http://dsp-psd.pwgsc.gc.ca/Collection/CP32-85-2002E.pdf> [*Romanow Commission Report*].

[99] See generally *Romanow Commission Report*, *ibid*. Some increased demands include: home adaptations; increased support and maintenance to facilitate aging in place; culturally-appropriate long-term care services; and comparable access to medication across all forms of insurance (public or private). See also Jeff Berryman, "Up in Smoke: What Role Should Litigation Play in Funding Canada's Health Care?" (2004) 12 Health LJ 125.

1. The Connection to Cancer Care

The development of many palliative care practices has historically arisen mainly out of cancer research, treatment, and care.[100] Such is largely still the case today. The palliative care initiatives taken in cancer care provide an excellent basis upon which to build a legal case for the expansion of those services. One way this can be accomplished is by demonstrating a disparity in care between those whose palliative care needs are cancer-related and those whose palliative care needs arise for other reasons.

Of Canadians who access hospice palliative care, 90% have cancer-related conditions, even though cancer-related deaths make up only one quarter of all deaths in Canada.[101] Similarly, a recent government report states that up to 85% of palliative care patients in Ontario have cancer.[102] These numbers demonstrate an emerging reality of disproportionate access and suggest unequal treatment of those who are suffering from non-cancer life-limiting conditions, such as Chronic Obstructive Pulmonary Disorder, neuromuscular degenerative conditions, cirrhosis, or congestive heart failure. Of course, there will likely be other groups for whom there is unequal access, but the authors do not have the empirical data to make those arguments at this time.

The authors turn to evidence from Alberta as one illustration of the arbitrariness of the current delivery system for palliative care in Canada.[103] Alberta

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[100] See Derek Doyle et al, *Oxford Textbook of Palliative Medicine* (Oxford: Oxford University Press, 2004) (citing several explanations why most palliative programs offer care mainly to cancer patients and their families). See also WHO, *Solid Facts*, *supra* note 26 at 7, 9, 12; Clark, *supra* note 3; CIHI, *Western Canada*, *supra* note 25 (suggesting that palliative care is more likely to be received "when death is somewhat more predictable, as in the case of cancer" at 82).

[101] See *2000 Senate Report*, *supra* note 47 at Part I.A. For similar statistics from Western Canada see CIHI *supra* note 25 at 59, 66, 78, 82.

[102] See Cancer Care Ontario, "Palliative and End-of-Life Care," online: CCO <www.cancercare.on.ca/cms/One.aspx?portalId=14473&pageId=15001>.

[103] A similar framework appears to be in place in Manitoba. See e.g. *CancerCare Manitoba Act*, RSM 1987, c C20, CCSM c C20, s 7. CancerCare Manitoba describes how palliative care is included in home care and sets out the eligibility requirements, see CancerCare Manitoba, "Home Care" online: CCM <www.cancercare.mb.ca/home/patients_and_family/patient_and_family_support_services/home_care/>. Compare Cancer Care Ontario, "Palliative Care Program" online: CCO <www.cancercare.on.ca/cms/one.aspx?pageId=8706>. See also Saskatchewan's *The Cancer Agency Act*, SS 2006, c C-1.1 ("The Lieutenant Governor in Council may make regulations: … (i) establishing eligibility requirements

was chosen because empirical data from this jurisdiction was readily accessible. As we will see, the apparent arbitrariness in palliative care provision is not remedied by federal government involvement.

In 1998, the Alberta Cancer Board created the Palliative Care Network Initiative to work toward providing equitable access to palliative care for Albertans "living with or affected by" cancer.[104] In February 2001, the Canadian Strategy for Cancer Control and Palliative Care Working Group issued a report that affirmed that palliative care is a fundamental component of cancer control.[105] It recommended that palliative care delivery within cancer care and other health care delivery systems be better integrated.[106] Later, in December 2003, a second national initiative, the Primary Health Care Transition Fund, allocated $4,317,000 to the Alberta Cancer Board (as lead and partner organization) for the creation of the Pallium Integrated Care Capacity Building Initiative.[107]

Like other Western Canadian provinces, Alberta addresses palliative care as part of its core services.[108] In 2008, Alberta Health Services issued a report that indicated that palliative care outside of cancer care is not as strong as within cancer specialities, stating that the Palliative and End of Life Care Institute "will bring added value if it creates comprehensive, integrated initiatives that meet the needs of cancer and non-cancer patients and address resource inequalities … Health care practitioners must forge ahead and remove barriers [rather]

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for persons to receive cancer care services or other services from the agency" s 20(i)); *Cancer Agency Regulations*, RRS c C-1.1, Reg 1, ss 4(1)-(2).

[104] Alberta Cancer Board, *The Alberta Cancer Board Hospice Palliative Care Network: Provincial Framework*, by Marie-Josée Paquin (Edmonton: Alberta Cancer Board, 2003) at 5, online: ACB <www.cancerboard.ab.ca/maco/pdf/hpcn_prov_framework_04-12-28.pdf> [Alberta Cancer Board, *Palliative Care Network*].

[105] See Silvana Luciani & Neil J Berman, "Canadian Strategy for Cancer Control" 21:1 Chronic Diseases in Canada 23.

[106] See Alberta Cancer Board, *supra* note 104. See also discussion in Carstairs, *Still Not There*, *supra* note 9 at 38.

[107] See Health Canada, "Pallium Integrated Care Capacity Building Initiative" (2006) online: Health Canada <www.apps.hc-sc.gc.ca/hcs-sss/phctf-fassp.nsf/lkAttachments/7952E21AB29242288525728F006C5DCE/$File/15E_SUM_PalliumCare.pdf> [Health Canada, "Pallium"].

[108] See Carstairs, "Motion" *supra* note 97 at 84.

than hinder the extension of palliative care beyond cancer."[109] Some of the commentary it gathered is particularly revealing of the disparities:

> One informant passionately spoke about her patients and serving their palliative care needs. She stated the central intake system is not working for them, that the needs of her patients are not being met by the program as it stands and that defining palliative care pertains more to cancer patients than anything.
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> …
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> Another informant spoke about liaising with the hospital consult team for inpatients and said, there are "*no palliative care physicians that we can refer our outpatients to*" the "*[RPCP] that's for cancer patients, they don't deal with [our] patients*," we "*can't draw on them for a resource right now.*" She stated it would be very beneficial if they had a palliative care physician in her specialty as a backup for outpatients.
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> …
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> Medical consultation and referral is often a barrier to patients accessing palliative care services. Physicians are not referring their patients to the palliative care program because there is uncertainty of what palliative care is about, what role palliative care plays as it exists today, resulting in specialties being "*somewhat narrow in their focus of palliative care*."[110]

Based on the foregoing, a preliminary observation might be made. Outside of the funding transferred pursuant to the *CHA*, the federal government, under a national initiative, has provided funding to support what is technically an extended service. The province controlling the funding is already providing that extended service (palliative care) as a provincial core service, yet the funding is directed only to a select group–namely, patients with cancer. As queried by Sandra McKinnon, is palliative care "just for cancer patients?"[111]

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[109] Alberta Health Services & Caritas Health Group, *The Palliative & End of Life Care Institute: A Summary Report of Findings From Key Informant Interviews and Two Additional Focus Group Sessions* (August–October 2008) at 1-2, online: Palliative.org <www.palliative.org/KI_Summary_Report_FINAL.pdf>.

[110] *Ibid* at 10-11[emphasis added].

[111] Sandra McKinnon, "Palliative Care: Just for Cancer Patients?" online: Palliative.org <www.palliative.org/PC/ClinicalInfo/Editorials/PCJustForCancerPatients.html>. See also CIHI, *Western Canada supra* note 25 ("As cancer patients become increasingly likely to have access to appropriate care at the end of life, an-

The above provides but a few examples of government laws, policies, and actions that may be discriminatory in terms of the delivery of palliative care. Further, there is no shortage of anecdotal discussion about unequal access to, and delivery of, palliative care across Canada. In the authors' view, however, more detailed research and analyses are needed regarding how the more than 430 palliative care programs and services are structured and delivered.[112] More research is also needed regarding the extent to which these palliative care programs and services meet the needs of those who require them. Such data would clarify the basis upon which a *Charter* argument in favour of a right to palliative care could be made. Regardless, the authors believe that the foregoing account establishes sufficient factual basis to proceed with an examination of potential *Charter* arguments for enforcing a legal right to palliative care on the basis of section 15.

Before turning to the case law, another observation should be made. There is little doubt that the government is providing a publicly-funded benefit (end-of-life care) to some and not to others. Whether you receive that benefit appears to be dependent on whether you are, for example, an in-patient or an out-patient, a veteran or an inmate, a cancer sufferer or a patient with chronic renal failure. Regardless of root cause, at the end of life the treatment needed is the same: care, compassion, and the alleviation of pain, psychosocial, and existential suffering.[113]

2. Equitable and Meaningful Access: The *Eldridge* and *Auton* Cases

Subsection 15(1) *Charter* provides:

> Every individual is equal before and under the law and has the right to equal protection and benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability.[114]

Section 15 provides that where a person interacts with the law, that person must be granted *substantive* equality. In other words, sometimes treating two

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other huge challenge now awaits: the delivery of expert palliative care to those with non-malignant disease" at 82); *Romanow Commission Report*, supra note 98 at 182; Clark, *supra* note 2 at 437.

[112] See Carstairs, *Still Not There*, *supra* note 9 at 1.

[113] See generally Chochinov, "New Horizons," *supra* note 10; Chochinov, "Dignity, Essence of Medicine," *supra* note 58.

[114] *Supra* note 18 at s 15(1).

people identically is not equality. For example, a government program might require that a person be on the second floor of a building in order to access it. The rule treats everyone the same: everyone must be on the second floor. If there is no elevator, however, people requiring a wheelchair cannot access the program. There is thus an inequality in the program's delivery.

Hence, once the state provides a benefit to the public, it is obligated to do so in a non-discriminatory manner. The government must take measures to ensure that disadvantaged groups are able to benefit equally from government services. The equality rights under section 15 can therefore be seen to create positive human rights obligations once the government has already entered the field. The following cases establish this principle.

Eldridge v British Columbia

The *Eldridge*[115] case involved a challenge to the non-provision of sign-language interpreters to deaf persons seeking hospital medical services– namely, physician-delivered consultation and maternity care. The claimants argued that this omission by the hospital was in breach of the equality guarantee under section 15 of the *Charter*. The Supreme Court of Canada unanimously held that since hospital services were funded through the *Medical and Health Care Services Act*,[116] the hospital was implementing a government program. The *Charter* therefore applied, and the Province of British Columbia was obligated to provide translators to the deaf to ensure equal access to the core health benefits provided under the British Columbian scheme. In failing to provide translation services for the deaf, the Province had effectively denied to a particular group a benefit that was provided to the general population.

In a subsequent decision, *Auton (Guardian ad litem of) v British Columbia (AG)*, the Supreme Court focused on the distinction between "core" benefits

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[115] *Eldridge v British Columbia*, [1997] 3 SCR 624 [*Eldridge*]. The first ruling on s 15 by the Supreme Court of Canada was issued in *Andrews v Law Society of British Columbia*, [1989] 1 SCR 143, 56 DLR (4th) 1 [*Andrews*]. This case articulated the framework for the interpretation of s 15 equality rights cases which is to be applied in subsequent determinations on s 15 violations by lower courts. The framework was to a certain extent reformulated in *Law v Canada (Minister of Employment and Immigration)*, [1999] 1 SCR 497, 170 DLR (4th) 1, to underscore a "heightened focus on human dignity." See also discussion in Hurley, *supra* note 66.

[116] SBC 1992, c 76, as amended by *Medicare Protection Act*, RSBC 1996, c 286.

already available to everyone under the provincial health care scheme and "non-core" services.

Auton (Guardian ad litem of) v British Columbia (AG)

The *Auton*[117] case involved a challenge relating to a service that was not covered under the public health insurance scheme and thus addressed the "comprehensiveness" criterion under the *CHA*. In *Auton*, a behavioural treatment for pre-school aged children with autism (known as Intensive Behavioural Intervention or IBI) was not funded by the provincial scheme. Other programs for autistic children between the ages of three and six, however, were funded provincially. The decision to deny funding to IBI was in part due to the emergent nature of the treatment, which was only beginning to be recognized as desirable, as well as fiscal imperatives. The issue was therefore whether section 15 required the provincial health insurance scheme to include all services that might improve an illness or condition.

In accordance with *CHA* requirements, complete funding was only available under British Columbia's legislation for medical services considered to be core services. The provincial plan did not fully fund non-core services involving other health practitioners, despite the fact that they might be considered medically necessary or required.

According to the Supreme Court, the claimants did not establish unequal treatment under section 15(1), since they did not show that they failed to receive a benefit that the law was providing.[118] This is the key distinction between *Auton* and *Eldridge*. In *Eldridge*, the service being provided was provided to everyone; thus, equal access to core services (physician and hospital services) was required–the benefit-granting law had to be applied in a non-discriminatory fashion. By contrast, *Auton* was concerned with "access to a benefit that the law has not conferred"; there was no denial of access to core benefits.[119] That being said, however, the court went on to explore, *inter alia*, the following two questions: (i) what of the non-core services for autistic children that were receiving funding? (ii) could they form a basis for demonstrating discrimination on the part of the government?

The Court stated that it is an "anticipated feature of the legislative scheme" that not all services will be covered and, accordingly, the exclusion of a non-

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[117] *Auton*, *supra* note 95.

[118] *Ibid* at paras 27-47.

[119] *Ibid* at para 38 [emphasis in the original].

core service from coverage is not an adverse distinction based on an enumerated ground.[120] If it were otherwise held, it would "effectively amend the Medicare scheme and extend benefits beyond what it envisions: core physician-provided benefits plus non-core benefits at the discretion of the Province."[121] Accordingly, equality does not require the government to eliminate or ameliorate all pre-existing disadvantages or create a new benefit or program for an individual or group.[122] Section 15 is not intended to eliminate all distinctions in law, only those that are discriminatory.[123]

3. Section 15 as Applied to Palliative Care

The *Auton* case demonstrates the great difficulty of using equitable access arguments as a basis for extending a service when the government is providing that service on the basis of a discretionary policy, as opposed to on the basis of legislation. As mentioned earlier, the *Charter* does not require a government to fund extended services. However, once any level of government (federal, provincial or territorial) enters into this arena and covers the cost of certain extended services, those services must be provided in a non-discriminatory manner.[124]

The *Auton* decision may appear, at first, to constitute a very large hurdle because of the difficulties that are bound to be encountered in trying to extend funding for palliative care, as if it were a core service. While there is increasing support for the position that palliative care should be included as an insured service under the *CHA*,[125] and, indeed, certain provinces do assert that it is a core provincial service on the basis of a discretionary policy, legislatively we are not yet there.[126]

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[120] *Ibid* at para 43.

[121] *Ibid* at para 44.

[122] See Robert E Charney & Zachary S Green, "*Auton* and *Chaoulli*: Who Decides the Future of Health Care in Canada?" (2005/2006) 19 NJCL 263 at 271.

[123] Hurley, *supra* note 66 at 2 (discussing *Andrews*).

[124] *Ibid*.

[125] See Senate, *End-of-Life Care*, *supra* note 46 at 30-31. See Carstairs, *Still Not There*, *supra* note 10 at 3. See *Romanow Commission Report*, *supra* note 98 at xxxi, 63, 172.

[126] Provincial governments (such as Manitoba and Alberta) have identified palliative care as a core service and palliative care is paid for out the provincial budget without a federal cash contribution. Nonetheless, the authors have already indicated that the delivery is at best uneven (depending in large part on the root cause of the

Unlike the treatment in *Auton*, however, palliative care is not a new or emergent treatment.[127] Indeed, "[p]alliative care has matured over recent years, with little doubt that end-of-life care providers are better positioned to address various sources of symptom distress than ever before."[128] Both best practices[129] and empirically-derived models of palliative care have been developed.[130] Palliative end-of-life care cannot be considered a therapy "fresh off the drawing board,"[131] and is thus distinguishable from IBI in *Auton*. It has had the benefit of years of development, improvement, refinement, and research.[132]

The established practice of palliative end-of-life care is an important consideration because in *Auton*, the relevance of the discussion surrounding IBI as an emergent technology did not concern clinical effectiveness or the desirability of funding. Rather, it concerned the "appropriateness of the comparator group used in the *Charter* section 15 analysis."[133] As described by the Court, "[p]eople receiving well-established non-core therapies are not in the same position as people claiming relatively new non-core benefits."[134] We agree with this distinction.

In the view of the authors, the Court is indicating that established non-core therapies may be treated differently than emergent non-core benefits, such as those sought in *Auton*. Palliative care is clearly well established, and those who would claim a right to non-core palliative care are claiming precisely *the same type of care* as those who are actually receiving funded non-core palliative care.

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need for care, such as cancer). This apparent arbitrariness in itself justifies a s 15 challenge. Again, more empirical and statistical information is required.

[127] See also Doyle, *supra* note 100.

[128] Chochinov, "New Horizons," *supra* note 10 at 84.

[129] See e.g. the establishment of the Best Practices and Quality Care Working Group in 2002, which since 2003 has been working with Accreditation Canada to influence hospice palliative care accreditation standards across Canada. See also Frank D Ferris et al, *A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice* (Ottawa: Canadian Hospice Palliative Care Association, 2002), online: CHPCA <www.chpca.net/uploads/files/english/resource_doc_library/model_to_guide_hpc/A+Model+to+Guide+Hospice+Palliative+Care+2002-URLUpdate-August2005.pdf>.

[130] See Chochinov, "New Horizons," *supra* note 10 at 92-93.

[131] Charney & Green, *supra* note 122 at 273.

[132] See Chochinov, "New Horizons," *supra* note 10 at 84.

[133] Charney & Green, *supra* note 122 at 273.

[134] *Auton*, *supra* note 95 at para 55.

To be clear, the argument made here is not aimed at transforming non-core services into core services. This was the argument made in *Auton* and it was rejected: there is no "right" to non-core benefits. Here, however, the suggestion is that once the government has exercised its discretion to provide specific non-core services, these non-core services should be provided in a non-discriminatory manner. In the case of palliative care, policy decisions have been made to provide services to a group that is suffering from a particular life-limiting condition, namely, cancer. In order to not be discriminatory, those who suffer equally from other life-limiting conditions (and thus have an equal need for end-of-life care) should be entitled to the same government benefit. The root cause of the suffering should be irrelevant, otherwise discrimination is present.[135]

In *Auton*, therapy A was a funded non-core therapy for autism. The plaintiffs believed that the failure to fund therapy B for autism was discriminatory. However, the Court was clear that the funding of therapy A did not make a refusal to provide funding for therapy B discriminatory. In other words, the same root cause was treatable via two different therapies, A and B, the latter of which was emergent. In the case of palliative care, we have the same therapy, A, but two (or more) different root causes, Y and Z. The argument is that one therapy, therapy A, must not be funded on a basis that discriminates between root causes Y and Z. Furthermore, the emergent nature of the therapy at issue in *Auton* was a key factor in the court decision. Palliative care is an established branch of medicine. For these reasons, *Auton* is not directly applicable.

A second, and perhaps stronger, section 15 argument also presents itself. The federal government has provided funding in certain circumstances to assist cancer-based palliative care initiatives.[136] Nonetheless, palliative care is typically perceived as extended care because of the operation of the *CHA*. This statute sets out that only medically "necessary" or "required" services are "insured" services for the purposes of the cash transfer. This terminology of "necessary" or "required" is not fully defined in the legislation, apparently in order to permit the exercise of discretion by the provinces in determining coverage under their provincial health insurance plans. Outside of the in-patient setting, most palliative care will not be federally insured care (under the *CHA*) because it falls into that broader category of extended care, leaving it to provincial discretion.

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[135] See *Nova Scotia (Workers' Compensation Board) v Martin*, 2003 SCC 54, [2003] 2 SCR 504 [*Martin*]. The case is discussed in further detail under sub-part (2) below.

[136] Health Canada, "Pallium," *supra* note 107.

This begs the question, why is it that palliative care is not, for the most part, considered medically "necessary" or "required" under the *CHA*? This is not a new question. In fact, the concern as to what exactly is "medically necessary" has been present since the formation of the public health care system in Canada in the 1960s and was reconsidered when the *CHA* was created in the 1980s.[137] Part of the answer is that palliative care is specialized care necessarily delivered by a team of health professionals, as opposed to care delivered solely by physicians. There is more to palliative care than medical assistance.[138]

The other part of this answer, however, lies in the translation of health care via the *CHA* into an "illness-oriented hospital-dominated health system"[139] with a *cure* focus. Indeed, a study undertaken in Alberta in 2001 indicated that 52% of hospital stays that ended in death were not "treatment intensive," meaning that very little was done in terms of surgery or major diagnostic procedures.[140] This study and others indicate that when a patient is dying, or a terminal diagnosis is made, resource expenditures on that particular patient are reduced.[141] Dying requires care, but not cure, and it is only cure-focussed care that tends to be insured under the *CHA*.

Section 15 requires not only that there be an enumerated ground (dealt with below), but also that there be a comparison between one group receiving government benefits and the group which is asserting a constitutional right to those same or similar benefits.[142] In this case, when one compares those who have conditions that are curable to those whose conditions are life-limiting, the distinction is quite stark. In other words, the treatment of those who can be "cured" is generally funded through the *CHA*, while those who cannot be cured are generally left without the benefit of the *CHA* and its five principles: accessibility, public administration, comprehensiveness, universality, and portability.

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[137] See Donna Wilson, "Medically Necessary? The Case for Fully Funded End-of-Life Care" (2002) 10:3 Health Law Review 3 at 3.

[138] Brenda Gibson, **"**Volunteers, Doctors Take Palliative Care Into the Community" (1995) 153:3 Canadian Medical Association Journal 331 at 331.

[139] Wilson, *supra* note 137 at 3.

[140] *Ibid* at 4.

[141] *Ibid* at 4.

[142] *Hodge v Canada (Minister of Human Resources Development)*, 2004 SCC 65 at paras 17-23, [2004] 3 SCR 357.

In the view of the authors, this care versus cure distinction is also relevant when discussing section 7. We therefore return to this debate in the context of our section 7 discussion in Part II.D(4). In the section below, we discuss the final element of a section 15 challenge–namely, an enumerated or analogous ground.

4. The Enumerated Ground: Discrimination by Virtue of Disability

Proceeding with the first section 15 argument, identified above, one of the key elements of a section 15 challenge is that there must not only be discrimination against the citizen, but this discrimination must also be based on either (i) one of the grounds specifically enumerated in the section (race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability), or (ii) a ground analogous[143] to those enumerated.

Disability is a ground of prohibited discrimination pursuant to section 15. The use of the word "disability" recognizes that whatever the cause of the impairment, the disability is the loss of a level of functioning that is considered normal[144] and thus includes illness. While the inclusion of disability in section 15 can be concerned with distinctions between persons who have disabilities and those who do not, it can also be used to ensure non-discrimination between groups with different disabilities. Just as "family status" encompasses a variety of relationships (including those who are married, single, with children, and so on),[145] so does disability encompass a variety of different groups. Thus, there can be discrimination between groups of persons with different disabilities.

Long-term care is generally perceived as a form of extended care and is therefore not subject to the universality and accessibility guarantees under the

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[143] Examples of analogous ground are citizenship (see *Andrews*, *supra* note 115) and sexual orientation (see *Vriend v Alberta*, [1998] 1 SCR 493, 156 DLR (4th) 385 [*Vriend* cited to SCR]).

[144] The World Health Organization's *International Classification of Functioning, Disability and Health* defines disability as "the outcome or result of a complex relationship between an individual's health condition and personal factors, and of the external factors that represent the circumstances in which the individual lives" World Health Organization, *International Classification of Functioning, Disability and Health, Short Version* (Geneva: WHO Publications, 2001) at 23.

[145] See *B v Ontario (Human Rights Commission)*, 2002 SCC 66, [2002] 3 SCR 403 at paras 38-39, 53-57 (while *B v Ontario* was not a *Charter* challenge, many of the principles espoused in this case could be applied in *Charter* litigation).

CHA.[146] Yet, when they form part of cancer-care, in many provinces, long-term care and palliative care are available and covered by public insurance.[147] Factually, there is no distinction between the need for palliative care arising out of a cancer-based illness, on the one hand, and other life-limiting illnesses on the other. All palliative care requires the management of pain and suffering.[148] Thus, under the operation of the federal *CHA*, in conjunction with provincial cancer-care legislation and activities occasionally funded in part by the federal Parliament, palliative care is being provided for certain individuals and not for others. This is a form of discrimination between disabilities. By favouring one root cause of impairment over another, there can be little doubt that a distinction has been made between cancer and other conditions that require palliative care and that this distinction is based on an enumerated ground.

Because benefits are being granted to a particular group based on fortuitous circumstances, it is, arguably, not open to government to limit benefits for others who are suffering from precisely the same circumstances, on the basis of a different disabling condition. This is a denial of equal benefit under the law.

Indeed, the Supreme Court had the opportunity to consider discrimination between disabilities in a 2003 case, *Nova Scotia (Worker's Compensation Board) v Martin*.[149] In *Martin*, two individuals who suffered from chronic pain challenged legislation that excluded them from coverage under the regular workers' compensation system. The appellants argued that the legislation discriminated against them on the basis of disability and denied them equal benefit under the law and, as such, infringed section 15(1) of the *Charter*. In finding that section 15(1) had been infringed, the Supreme Court stated:

> By entirely excluding chronic pain from the application of the general compensation provisions of the Act and limiting the applicable benefits to a four-week Functional Restoration Program for workers injured after February 1, 1996, the Act and the FRP Regulations clearly impose differential treatment upon injured

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[146] See *CHA*, *supra* note 22, s 2 which defines "extended health care services" as: "the following services, as more particularly defined in the regulations, provided for residents of a province, namely, (a) nursing home intermediate care service, (b) adult residential care service, (c) home care service, and (d) ambulatory health care service." See generally Sholzberg-Gray, *supra* note 78.

[147] See discussion at II.B above.

[148] See generally Chochinov, "New Horizons," *supra* note 10. See also *Romanow Commission Report*, *supra* note 98 at 183.

[149] *Martin*, *supra* note 35.

> workers suffering from chronic pain on the basis of the nature of their physical disability, an enumerated ground under s. 15(1) of the *Charter*. *In the context of the Act, and given the nature of chronic pain, this differential treatment is discriminatory. It is discriminatory because it does not correspond to the actual needs and circumstances of injured workers suffering from chronic pain, who are deprived of any individual assessment of their needs and circumstances. Such workers are, instead, subject to uniform, limited benefits based on their presumed characteristics as a group. The scheme also ignores the needs of those workers who, despite treatment, remain permanently disabled by chronic pain* … The challenged provisions clearly violate s. 15(1) of the *Charter*.[150]

With respect to palliative care delivery and access, we do not have a piece of legislation that we can specifically point to as a breach of section 15, making our task particularly challenging. As a general proposition, the *Charter* does not impose positive duties to act.[151] The authors nonetheless argue that the decisions of the federal and provincial governments, having chosen to enter into the domain of palliative care by providing funding for palliative care services, are subject to the *Charter*, including the obligation to cover everyone, who, under section 15, has a constitutional right to be included.[152] Cancer care provides one example where end-of-life care is being delivered on an unequal footing and may therefore provide the basis for a valid *Charter* argument to provide palliative care to all who require it.[153]

Of course, this raises the question of what remedy would be appropriate, assuming a section 15 breach is found. If the fault lies not with legislation (as might very well be the case with respect to palliative care delivery and access), but rather with the exercise of discretionary power, the remedy might only be a simple issuance of a declaration and an instruction to government to remedy the situation.[154] However, whatever the remedy, an authoritative statement by the Supreme Court as to the existence of a constitutional right to palliative care

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[150] *Ibid* at para 5 [emphasis added].

[151] See *Vriend*, *supra* note 143 at 532-536.

[152] *Ibid*.

[153] See comments by Sholzberg-Gray, *supra* note 7878.

[154] On this point see the discussion of the adequacy of a declaratory remedy in *Little Sisters Book and Art Emporium v Canada (Minister of Justice)*, 2000 SCC 69, [2000] 2 SCR 1120 [*Little Sisters*].

may spur government action to provide the care that many need, but which they may not be receiving under the current system.

D. Section 7 of the Charter

Section 15 is not the only route to judicial recognition of a constitutional right to palliative care. Section 7 of the *Charter* may also be useful in achieving this objective. Section 7 provides as follows: "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."[155]

The case law has developed a two-pronged analysis with respect to section 7. First, the claimant must show that there is a real or impending deprivation of one of the following guarantees: (i) life; (ii) liberty; or (iii) security of the person. Second, it must be shown that the deprivation is not in accordance with the principles of fundamental justice.[156] The question here, then, is whether reasonable arguments may be advanced on both prongs, suggesting that section 7 has been infringed due to the failure of the federal and provincial governments to provide meaningful, universal palliative care coverage, pursuant to the *CHA* and provincial health care plans. In the view of the authors, the answer to this question is in the affirmative.

1. Violation of Security of the Person

The security of the person involves protection of "both the physical and psychological integrity of the individual."[157] Sufficient psychological stress placed on an individual will constitute an affront to the security of the person.[158] Not every stress, however, is sufficient for section 7 protection: "the ordinary stresses and anxieties that a person of reasonable sensibility would suffer as a result of government action" will not be protected by section 7.[159] The majority in the *G (J)* decision explains:

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[155] *Charter*, *supra* note 18 s 7.

[156] See *Reference re Section 94(2) of the Motor Vehicle Act (BC)*, [1985] 2 SCR 486 at 500-504 [*Motor Vehicle Reference*].

[157] *New Brunswick (Minister of Health and Community Services) v G (J)*, [1999] 3 SCR 46 at 76-77, Lamer CJC, and at para 116, L'Heureux-Dubé J, concurring [*G (J)*].

[158] *Ibid* at 77-78, Lamer CJC.

[159] *Ibid* at 77, Lamer CJC.

> For a restriction of security of the person to be made out, then, the impugned state action must have a *serious and profound effect on a person's psychological integrity*. The effects of the state interference must be assessed objectively, with a view to their impact on the psychological integrity of a person of reasonable sensibility. This need not rise to the level of nervous shock or psychiatric illness, but *must be greater than ordinary stress or anxiety.*[160]

Those seeking palliative care are already under the psychological stress of dealing with a life-limiting illness. They are in the vulnerable position of being unable to manage their care needs and pain without significant social, medical, or pharmaceutical intervention. Because the federal scheme that operates to classify the majority of palliative care services places them outside of insured care,[161] the government adds a significant amount of stress to the lives of those who are already under extraordinary strain.

Without access to integrated palliative care, many people with life-limiting illnesses will potentially be faced with a dilemma: live out their remaining days in pain and suffering (including spiritual and existential suffering), without the care that would relieve their suffering and feelings of being a burden to others, or consider ways to end their suffering by hastening death or committing suicide.[162] While some may suggest that there is no direct evidence of this dilemma, the authors believe that current empirical data appears to support this linkage.[163] As described by Dr Harvey Chochinov:

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[160] *Ibid* at 77-78, Lamer CJC [emphasis added].

[161] See Sholzberg-Gray, *supra* note 7878 at 284.

[162] For further discussion of the relationship between desire for hastened death and palliative care, see Chochinov, "New Horizons," *supra* note 10; Deborah Dudgeon, "Excellent Palliative Care, Not Euthanasia" in Barney Sneiderman & Joseph M Kaufert, eds, *Euthanasia in the Netherlands* (Winnipeg: The Legal Research Institute, 1994) 81 at 81-85.

[163] "Over the last decade, much work has been done to establish the incidence and prevalence of psychiatric issues among patients nearing death. For example, [the prevalence of] anxiety disorders in terminally ill cancer and AIDS patients ranges from 15% to 28%, with some studies indicating a higher prevalence of mixed anxiety and depressive symptoms in cancer patients rather than anxiety alone. The prevalence of anxiety appears to increase with advancing disease and mounting deterioration in the patient's physical status. As patients become sicker, their anxiety may include fears about the disease process, the clinical course, possible treatment outcomes, and death … Although screening strategies as simple as ask-

> More ubiquitous aspects of suffering–including psychological, existential, or spiritual distress–are not necessarily well understood or researched, nor do they necessarily engender a well-considered response. Distress of this kind may express itself as an overwhelming sense of hopelessness, existential or spiritual angst; loss of sense of dignity; sensing oneself a burden to others; or a waning of one's will to live and a growing desire for death or wish to no longer carry on living.
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> …
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> Among patients with life-threatening illness, sensing oneself as a burden to others seems to be an important theme related to quality of life, optimal palliative care, and maintenance of dignity at the end of life. Personal or individual autonomy–especially in Western society–is often conflated with the notion of being a whole person, so that dependency can be seen or experienced as threatening the integrity of personhood itself. Therefore a bad death is frequently characterized by "feeling a burden to others" and is often invoked in matters pertaining to suicide or requests for hastened death among patients with advanced disease.[164]

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ing the patient if they are depressed 'most of the time' have shown good diagnostic sensitively and specificity, depression continues to be overlooked among patients who are terminally ill. This further adds to their burden of suffering and undermines their quality of life" (Chochinov, "New Horizons" *supra* note 10 at 86). See also LJ Materstvedt et al, "Euthanasia and Physician-Assisted Suicide: A View From an EAPC Ethics Task Force" (2003) 17:2 Palliative Medicine 97; Marije L van der Lee et al, "Euthanasia and Depression: A Prospective Cohort Study Among Terminally Ill Cancer Patients" (2005) 23:27 Journal of Clinical Oncology 6607 (An empirical discussion on connections between terminal illness and depression in terminally ill cancer patients and explicit requests for assisted suicide).

[164] Chochinov "New Horizons," *supra* note 10 at 86-87 ("According to reports from family members of patients who had died after having previously expressed a wish for hastened death, 58% to 94% were distressed about being a burden to others. Physicians who had been asked to assist with death-hastening measures indicated that patients' concerns about being a burden to others was a motivating factor in 41% to 75% of requests. Among dying patients who actually killed themselves, feeling a sense of burden to others was almost universal. Data from Oregon indicates that 63% of patients who received a hastened death under that state's Death with Dignity Act had expressed a strong sense of having become a significant burden to their family, friends, or caregivers. The authors further report that this motivation for death-hastening practices is becoming more prominent over time" at 91).

There can be little doubt that the general exclusion of palliative care from insured services under the *CHA*, which shifts the obligation to provincial discretion, means that governments are adding to the psychological stress of those who require such care. The effect is surely greater than the "ordinary" stress of life, as articulated by the Supreme Court of Canada.

When appropriate palliative care is provided, additional options become available to the person suffering from the life-limiting illness. At minimum, the person's physical pain can be managed regardless of his or her financial circumstances. Spiritual and existential pain can also be addressed: the person can "not only be made to feel more comfortable, but more broadly, provided with comfort" in accordance with current palliative care best practices.[165] When a person is comforted in these ways, suicide may be a less prevalent alternative.[166] Unremitting pain and suffering that cannot be relieved can be a pre-condition to a desire for death-hastening practices.[167] That the decision to shorten one's life can be influenced by a lack of access to appropriate palliative care options cannot be ignored.[168]

These realities may also support an argument that the section 7 "life" interest is also engaged. Current empirical evidence regarding the physical and psychological suffering at the end of life, some of which has been described above, suggests that a failure to provide access to palliative care in accordance with current best practices may increase the likelihood of the loss of life and therefore infringes the "life" interest under section 7. In *Chaoulli*, four of the seven justices held that the "life" interest under section 7 became engaged even though there was no statistical evidence to prove that people had actually died as a result of the government policy at issue.[169] On the balance, the "life" interest under section 7 may not be as clearly engaged as the "security of the

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[165] Chochinov, "New Horizons," *supra* note 10 at 84.

[166] See e.g. LJ Materstvedt et al, *supra* note 136 at 65.

[167] *Ibid*. See also van der Lee et al, *supra* note 163; Carstairs, *Raising the Bar*, *supra* note 6 ("As one physician said in a written brief, 'The antithesis to deliberate ending of life is good palliative care'" at 13).

[168] For additional arguments on how obligations under the *ICESCR* require prioritizing the palliative care agenda over the assisted suicide agenda see Shariff, "Navigating Assisted Death" *supra* note 15.

[169] *Chaoulli v Québec (AG)*, 2005 SCC 35 at para 112, [2005] 1 SCR 791, McLachlin CJC & Major J [*Chaoulli*] (Bastarache J concurring). See also *Chaoulli* at paras 37-38, 40-42, Deschamps J (holding that the Canadian *Charter* and *Québec Charter* protect the right to "life" in the same way, and that the *Québec Charter*'s right to life was infringed by wait lists even without strong proof of mortality).

person" interest. Regardless, the engagement of either will be sufficient to allow the argument to proceed to the next stage of the analysis.

Note that the authors are arguing that the general exclusion of palliative care from insured services under the *CHA* constitutes interference with security of the person. This could be somewhat problematic because it might be interpreted as simply state inaction, whereas the law requires actual state action or interference with security to constitute infringement of section 7. However, it might, in turn, be argued that the decision to place palliative care outside of insured services was not merely inaction, but a specific policy choice, engaging section 7 rights. Thus, the task that remains is to seek out and identify examples of state action in the delivery of and access to palliative care that increases the psychological stress of those who have life-limiting conditions.

2. Violation of the Principles of Fundamental Justice

It is well established that the principles of fundamental justice are found in "the basic tenets of our legal system"[170] and that one of these principles is lack of arbitrariness.[171] As Chief Justice McLachlin and Justice Major explained:

> A law is arbitrary where "it bears no relation to, or is inconsistent with, the objective that lies behind [it]." To determine whether this is the case, it is necessary to consider the state interest and societal concerns that the provision is meant to reflect.
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> In order not to be arbitrary, the limit on life, liberty and security requires not only a theoretical connection between the limit and the legislative goal, but a real connection on the facts. The onus of showing lack of connection in this sense rests with the claimant. The question in every case is whether the measure is arbitrary in the sense of bearing no real relation to the goal and hence being manifestly unfair. The more serious the impingement on the person's liberty and security, the more clear must be the connection. Where *the individual's very life may be at stake, the reasonable person would expect a clear connection, in theory and in fact, between the measure that puts life at risk and the legislative goals*.[172]

The authors have already addressed how the individual's very life may be at stake by virtue of the non-provision of palliative care options to all those who

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[170] *Motor Vehicle Reference*, *supra* note 156.

[171] *Chaoulli*, *supra* note 169 at para 125, McLachlin CJC & Major J.

[172] *Ibid* at paras 130-131 [emphasis added].

need them. Based on the wording adopted by some justices in *Chaoulli*, this might be sufficient, but additional elements should also be considered.

Access to publicly funded palliative care can be seen as arbitrary in the sense that access to insured palliative care services is, arguably, not based on meaningful criteria. For example, as discussed above, the vast majority of government spending on palliative care at both the federal and provincial levels appears, in many cases, to be connected to a particular diagnosis–namely, cancer–as opposed to the need for palliative care itself. While the authors stress that they are not challenging the importance of or need for palliative care in cancer-related treatment, it is a legitimate legal task to explore whether the apparent exclusion of other diagnoses from fully funded palliative options is arbitrary.

3. The Interplay between Sections 7 and 15

While each *Charter* right is to be judged individually, they are not entirely independent of one another. In the case of palliative care, the values that underlie section 15 can influence the analysis under section 7. In the concurring opinion of Justice L'Heureux-Dubé in *G(J)*, the learned justice chose to specifically address the connection between sections 7 and 15 of the *Charter*, writing:

> Thus, in considering the s. 7 rights at issue, and the principles of fundamental justice that apply in this situation, it is important to ensure that the analysis takes into account the principles and purposes of the equality guarantee in promoting the equal benefit of the law and ensuring that the law responds to the needs of those disadvantaged individuals and groups whose protection is at the heart of s. 15. *The rights in s. 7 must be interpreted through the lens of ss. 15* and 28, to recognize the importance of ensuring that our interpretation of the Constitution responds to the realities and needs of all members of society.[173]

The authors take this to mean that, where the violation of the rights protected by section 7 (life, liberty, or security of the person) would have a disproportionate impact on those groups protected by the equality guarantee found in subsection 15(1), a careful analysis of the relationship between principles of fundamental justice, on the one hand, and the importance of equality, on the other, is required.

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[173] *G(J)*, *supra* note 157 at para 115 [emphasis added].

One means of linking section 7 to section 15 is to consider precisely *where* health care money is being spent. As explained by the Supreme Court: "The *Charter does not confer a freestanding constitutional right to health care*. However, where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*."[174] There is no constitutional requirement to provide health care, according to the Supreme Court. Yet, *if* the government introduces a program, that program must be provided in accordance with all constitutional guarantees. Equality is only genuine where it is substantive, as opposed to formal, in nature.[175] One can judge the substantive equality of a health program only in the broader context of the operation of that program. If it is indeed the case that an exceptionally large percentage of government money spent on palliative care goes to addressing a particular disease–namely, cancer–then the distribution of resources could be deemed arbitrary in the sense used by all the justices in *Chaoulli*. Furthermore, an unreasonable waiting list is sufficient to trigger arbitrariness in a law designed to deliver reasonable access to health care. This was found to be the case in *Chaoulli* by Chief Justice McLachlin and Justice Major:

> The primary objective of the *Canada Health Act*, R.S.C. 1985, c. C-6, is "to *protect*, *promote and restore* the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (s. 3). By imposing exclusivity and then failing to provide public health care of a reasonable standard within a reasonable time, the government creates circumstances that trigger the application of s. 7 of the *Charter*.[176]

4. Care versus Cure

Additional arbitrariness in access and delivery lies in the differential treatment of those who have disabilities that are relatively temporary in nature and those who have disabilities that are unlikely to improve during their lifetimes, that is, those with life-limiting illnesses. This might be described as a "care" versus "cure" distinction, which appears to exist in many areas of medical practice where it is thought that only curative measures are medically relevant,

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[174] See *Chaoulli*, *supra* note 169, McLachlin CJC & Major J, at para 104 [emphasis added].

[175] *Andrews*, *supra* note 115.

[176] See *Chaoulli*, *supra* note 169 at para 105 [underlining in original; italics added].

notwithstanding issues of pain control.[177] This distinction was discussed earlier with reference to section 15. Indeed, the language of the *CHA*, "to *protect*, *promote and restore* the physical and mental well-being of residents of Canada,"[178] is clearly focused on preventing and curing threats to well-being as opposed to providing care to those whose illnesses are beyond the point at which a cure may be reasonably expected.

The difficulty with this approach is that it ignores the social model of disability. While the "cure" focus is perhaps understandable, given the biomedical orientation of the *CHA*,[179] most people knowledgeable in the field of disability studies view disability not as a matter of medical pathology, but as a matter of social construction.[180] For example, a person who uses a wheelchair for mobility is, according to the social model of disability, not disabled merely as a result of the medical condition. Rather, the disability is a result of the fact that the built environment has far too many structures that cannot accommodate the needs of those who use wheelchairs for mobility.[181] From this perspective, there is little doubt that people who require palliative care are disabled to the extent that their ability to interact in society is severely hampered. Because there is no chance to medically improve or protect the health of the patient, however, this social reality does not enter into the equation. In other words, a "cure" interpretation of the *CHA* is arguably a violation of section 15 of the

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[177] For example, "Palliative care has matured over recent years, with little doubt that end-of-life care providers are better positioned to address various sources of symptom distress than ever before. It is also clear that the distinction between somatic distress and psychological or spiritual disquietude becomes less clear and increasingly entangled as death draws near. Yet, there is an inclination for care providers to parse these out, focusing on those things that seem within our grasp to attenuate, while neglecting those we sense are beyond reach" (Chochinov, "New Horizons," *supra* note 10 at 84).

[178] *CHA*, *supra* note 22 s 3 [emphasis added].

[179] In the biomedical model of disability, there is a focus on the pathology or disease that "creates" an inability to carry out normal functions. For example, with a person who has a mobility impairment, the disability is a result of the pathology of the condition that is the medical "cause" of the inability at issue.

[180] Jerome E Bickenbach, *Physical Disability and Social Policy* (Toronto: University of Toronto Press, 1993) at 136-149.

[181] While this is not necessarily the forum in which to make this argument, the authors believe that constitutional guarantees require a broader view of disability. After all, the rights under the *Charter* are to be construed purposively. See e.g. *R v Big M Drug Mart*, [1985] 1 SCR 295, 60 AR 161, 18 DLR (4th) 321.

Charter. Indeed, it intimates that there exists a systemic denial of rights at the very foundation of the health care system in Canada.

What should replace the "cure" perspective? Quite simply, access to health care should be determined on the basis of need. If caring for the person is as important as curing the person,[182] palliative care should fall within the definition of "insured services" under the *CHA* and, in fact, justice demands it.

The authors do not advance this argument lightly, given that resource allocation decisions must be made on a daily basis. In *Chaoulli*, the possibility of instructing the government to deploy more financial resources was clearly a concern even for the justices who believed that *Charter* rights had been unjustifiably infringed:

> The appellants *do not seek an order that the government spend more money on health care*, nor do they seek an order that waiting times for treatment under the public health care scheme be reduced. They only seek a ruling that because delays in the public system place their health and security at risk, they should be allowed to take out insurance to permit them to access private services.[183]

The authors understand and respect the concern espoused in this paragraph. Nonetheless, an appreciation of the right of government to determine its spending priorities should rarely be used to undermine the fundamental values of Canadian society. The *Charter* represents some of the core values of what it means to be Canadian. If Canadian society is willing to abandon those values in favour of economic considerations, what Canadian societal values will remain?

Notwithstanding the rhetorical nature of this question, two responses to this fiscal concern present themselves. First, where access to health care is concerned, the Supreme Court of Canada has ruled that the *Charter* mandates funding for services that the relevant statutory framework would not otherwise provide, as was the case in *Eldridge.* Therefore, the approach offered within this paper is not without precedent. While the class of people in that case (those in need of sign-language interpretation) was more limited as a class than

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[182] See Chochinov, "Psychiatry and Terminal Illness," (2000) 45:2 Canadian Journal of Psychiatry 143 at 143 (regarding the need for a care focus of the patient and how a cure-oriented focus is too narrow).

[183] *Chaoulli*, *supra* note 169, McLachlin CJC & Major J at para 103 [emphasis added].

those needing palliative care, the impact of the refusal to recognize this right is just as severe.

As mentioned earlier, the Supreme Court has already indicated that the possibility of death necessitates a more careful examination of the content of the principles of fundamental justice to ensure that a proper balance is achieved within the section 7 analysis. By extension, the general reluctance of the courts to force governments to spend money via constitutional imperative should be carefully examined where the refusal to prescribe spending could result in increasing suffering, to the point of potentially hastening death.

The authors acknowledge that this answer may be unpalatable to a court that is made to rule on a request for recognition of a constitutional right to palliative care. In such a case, there is an alternative argument: the constitutional right to palliative care does not demand that government spend more money on palliative care. Rather, the right demands that when money is spent on palliative care, that money must be spent in a non-discriminatory way. In the view of the authors, the interaction of sections 15 and 7 of the *Charter* may justify such a determination.

III. Limitations

A. Section 1

As described above, the government may be able to establish that the violation of a *Charter* protected right is permissible or "justified" under section 1. The framework for the justification of *prima facie* violations of constitutionally protected rights under the *Charter* was established by the Supreme Court in *R v Oakes*.[184] There are three stages to this analysis.

The first stage is whether the proposed limit is "prescribed by law." In the case of palliative care, there is no question that the distinctions made by or pursuant to the *CHA* are prescribed by law and present an intelligible standard to the public. However, if government action or policy is at the whim of a government official, and not mandated by statute, regulation, or the common law, it is not "prescribed by law" for the purposes of section 1 and such an infringement cannot be justified.[185]

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[184] *R v Oakes*, [1986] 1 SCR 103 [*Oakes*]. The *Oakes* test was later refined by: *Dagenais v Canadian Broadcasting Corporation*, [1994] 3 SCR 835; *RJR-Macdonald Inc v Canada (AG)*, [1995] 3 SCR 199.

[185] See *Little Sisters*, *supra* note 154 at paras 141, 145-146, 222-224. See also *Irwin Toy Ltd v Québec (AG)*, [1989] 1 SCR 927.

The second stage of the analysis is whether the objectives sought to be achieved by government through the law are "pressing and substantial." At this stage, the court requires that the government show that the law's objectives are sufficiently important to warrant overriding what are otherwise constitutionally protected rights.

If the objective is deemed sufficiently important at the second stage of analysis, the third stage of analysis proceeds to examine whether the government has chosen means proportional to the objective. This third stage may be viewed as having three sub-stages. The first of these sub-stages demands that the government demonstrate a *rational connection* between the objective and the means sought to achieve it. The second sub-stage involves proof of *minimal impairment*: whether the government has chosen a method of achieving its objective that can be reasonably said to impair the constitutionally protected right as little as possible. The third sub-stage is an assessment of proportionality. Here, the courts weigh both the salutary (positive) and deleterious (negative) effects of the government measure to determine whether the negative effect on the constitutionally-protected right is justified, given the positive effects of the law or of the measure chosen. As was established in *Chaoulli*, where the life of a citizen is at issue, the onus on the government is a heavy one. It should never be easy for the government to justify placing the lives of citizens at risk through legislative indifference.

Is there a justification for depriving one's constitutionally-guaranteed rights to equality under sections 7 and 15 in the context of palliative care? The authors believe there is not. It is true that government funding priorities are important and may even be important enough to constitute a pressing and substantial objective for the purposes of the *Oakes* analysis.[186] However, even assuming a funding crisis, the consequences of such a crisis should not be borne disproportionately by some of the most vulnerable members of our society. Of the approximately 15% of Canadians receiving palliative care,[187] 90% have accessed this care through cancer-care.[188] If there were ever a clearer argument for a lack of proportionality under the *Charter*, in the view of the authors, it is difficult to conceive of it.

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[186] See *Newfoundland (Treasury Board) v NAPE*, [2004] 3 SCR 381 (the Court held that a financial crisis to the public purse was sufficient for s 1 purposes. However, the Court was clear that, first, this would be rare, at para 72; second, financial reasons *alone* will never constitute a s 1 justification, at paras 69-71) [*NAPE*].

[187] Carstairs, "Motion," *supra* note 96 at 83.

[188] See *2000 Senate Report*, *supra* note 46 at Part I.A; CHPCA "Fact Sheet", *supra* note 30.

Section 1 has never been successfully invoked after a violation of section 7 has been found by the court, though the Supreme Court has recognized that, at least in theory, it is still a possibility.[189] In the absence of case law from which analogies might be drawn, it is difficult to conceive of an argument that governments could advance to justify the violation of section 7 pursuant to the *Oakes* test.[190] Once a basic tenet of the justice system has been violated by the government, it should be reasonably difficult (and thus relatively rare) for the government to show that a free and democratic society would allow the law to be enforced notwithstanding the violation. For example, an economic justification–that is, the argument that a right to palliative care would be too expensive and hamper government spending priorities–can be dealt with by defining the right carefully.[191] Furthermore, it is difficult to show that the government's choice to focus on "cure" over "care" minimally impairs the right at issue, when that constitutional right would be better protected if the government had not made the statutory choice in the first place.

To extend the section 1 analysis beyond the foregoing would enlarge this paper beyond its intended scope. If a right to palliative care is argued in court, the applicant will have to present empirical data on palliative care access and delivery in the Canadian health care system, requiring more work on all fronts. This leads us to our next point.

B. Lack of Empirical Data and Other Considerations

In advancing the legal right to palliative care, more empirical analysis must be done. Given the current lack of data, we can only conclude somewhat anecdotally that palliative care is not as integral a part of health care as it should be.[192] For the purposes of advancing an argument for the enforcement of palliative care as a legal right, further research is essential. There is an insufficient empirical foundation, for example, to state categorically whether decisions about appropriate palliative end-of-life care are being made for economic reasons, as opposed to being made in the best interests of the person requiring care.

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[189] See Hogg, *Constitutional Law*, *supra* note 68 at ch 47.3.

[190] *Oakes*, *supra* note 184.

[191] See *Martin*, *supra* note 135 ("[B]udgetary considerations in and of themselves cannot justify violating a *Charter* right, although they may be relevant in determining the appropriate degree of deference to governmental choices based on a non-financial objective" at para 6). See also *NAPE*, *supra* note 186.

[192] See discussion in Part III.B, *supra*.

It is also important to point out that advancing palliative care access and delivery does not rest on collecting data generated solely from the formal health care system. There are strong arguments in support of the notion that people requiring palliative care should receive integrated end-of-life care in their own homes and among their loved ones.[193] Not only is there good reason for this from the patient's perspective, but also from the government's economic perspective, as it is purportedly less expensive to provide palliative care in the home than in institutional settings.[194] However, this raises the following question: even if having palliative care among loved ones is preferable, are those who require it receiving the support they need?[195] A decision regarding the best form of palliative care should not necessarily be based on the shortage of hospital beds, or the existence of a caring relative at home. Instead, it should be the result of an assessment regarding the best interests of the person requiring care. Also to be considered are the interests of the individuals responsible for the provision of care at home, namely, adult children and the spouses of those requiring care, among others.

In order to proceed with a *Charter* argument, much more empirical data is needed, including qualitative research, as well as dissemination of that re-

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[193] WHO, *Solid Facts*, *supra* note 26 ("[m]ost studies have found that around 75% of respondents would prefer to die at home" at 16). See also *Romanow Commission Report*, *supra* note 98 at 182 (80% of Canadians prefer to die at home); CHPCA, "Fact Sheet" *supra* note 31 at 1-3.

[194] See Senate, *Canada's Aging Population*, *supra* note 98 at 167-168, which states: "[t]he evidence supports home care as a cost-effective substitute for residential long-term care. Departmentally, the average residential care facility cost for community care is approximately one quarter of the average cost for priority access beds available on a contracted basis." However, the report continued by noting that palliative care in the home has undesirable consequences for women and low income-earners: "[w]omen bear a disproportionate share of the informal caregiving work. While roughly equal numbers of men and women aged 45 to 65 are involved in informal caregiving, women are more likely to be high intensity caregivers" (Senate, *Canada's Aging Population*, *supra* note 98 at 117). See also discussion in Charmaine Spencer & Ann Soden, "A Softly Greying Nation: Law, Ageing and Policy in Canada" (2007) 2 Journal of International Aging, Law and Policy 1 at 22-25.

[195] For a summary of statistics concerning informal and family caregivers see CHPCA, "Fact Sheet," *supra* note 30; See also discussion in Valerie A Crooks & Allison Williams, "An Evaluation of Canada's Compassionate Care Benefit from a Family Caregiver's Perspective at End of Life" (2008) 7:14 *BMC Palliative Care*.

search across platforms related to medicine, aging, and other life-course issues.[196]

Conclusion

Trying to establish palliative care as an enforceable human right involves many obstacles. Efforts are being made to ground palliative end-of-life care as an enforceable right under certain international instruments that recognize rights to security, equality, and health, as well as the right to dignity. However, international treaties and documents are difficult to enforce in the absence of domestic legislation–a situation that prevails in Canada. Furthermore, the term dignity itself seems to elude categorical definition for legal purposes.

The need for Canadian palliative care services is increasing, although a significant portion of the populace cannot access them. To add to the confusion, while the majority of health care is delivered by the provincial and territorial governments, health care for some groups (such as current and former military personnel, Aboriginal persons, and federal prisoners) is the constitutional responsibility of the federal government. This has resulted in wide variations in the availability, quality, and delivery of palliative care across the country. Further increasing these variations, the preliminary evidence indicates that much of the government-funded palliative care hinges on a cancer diagnosis. Regardless of the source of the need for palliative-care services, the need for those services is the same. Care, compassion, and the alleviation of pain, and psychosocial and existential suffering, are all needed by those approaching the end of life, regardless of the underlying condition that necessitates palliative care.

In Canada, the *Charter* is the primary constitutional instrument whose jurisprudence addresses these issues. While there is also no express mention of palliative care–or even health, for that matter–in the *Charter*, some of the express protections contained therein may be broad enough to include constitutional protection for those in need of palliative care. In this paper, the authors have relied specifically on the *Charter* to put forward an argument that palliative care is a human right in Canada. In particular, sections 7 and 15 of the *Charter* are potential means of demonstrating the violation of a constitutional right to palliative care in Canada. There are two ways to demonstrate the right to palliative care. The first is by demonstrating a right to health care, and then showing that palliative care falls within that right to health care. The second

[196] Of course, there may be still other questions related to standing, evidentiary issues and more that are not mentioned here. To attempt to even list all of these potential issues would be beyond the scope of this paper.

approach is not based on a right to health care, but rather on the unequal delivery of health care services in Canada.

To summarize the first *Charter* argument: section 15 protects everyone from laws that draw discriminatory distinctions between those who receive a benefit from the law and those who do not. Legitimate distinctions are permitted; discrimination is not. The *Eldridge* case establishes that unequal access caused by the application of a law that provides a benefit can be discriminatory. Although the *Auton* case may appear, at first, to be contrary to the position advanced here, in the view of the authors, *Auton* presents a very different set of circumstances than would a challenge to the current palliative care regime in Canada. In *Auton*, the argument was that extended services should be treated as core services. If accepted, this would have eliminated extended services altogether, and treated every service as a core service. The argument made here is more nuanced, in that the argument relies on (among other things) the differential impact of the delivery of palliative care in order to make a finding of discrimination. Therefore, an argument can be made that equitable and meaningful access to palliative care is constitutionally mandated by section 15.

In addition to proof of discrimination itself, it must also be shown that the discrimination is on a ground enumerated in section 15, or one analogous thereto. Disability (either mental or physical) is one such enumerated ground. People with life-limiting illnesses are coping with suffering and this affects their activities of daily living; there is therefore a proven disability. There is jurisprudence suggesting that differentiation between disabilities in the provision of government support is discriminatory within the meaning of section 15. This suggests that a jurisprudential basis may exist to improve the availability of palliative end-of-life care through a constitutional challenge based on the *Charter*'s equality guarantee.

Furthermore, section 7 of the *Charter* could also be used to support a constitutional challenge. The right to security of the person is engaged because failure to provide adequate palliative care causes severe psychological stress, and the Supreme Court has previously ruled that serious and profound psychological stress is a violation of security of the person. Given that lack of integrated palliative care may also hasten the death of the person suffering from a life-limiting illness, this may also be sufficient to engage the right to life as guaranteed by section 7. If either interest is engaged, this challenge will pass the first stage of the section 7 analysis.

The second step of proving a *prima facie* section 7 violation is to show that the violation is not in accordance with the principles of fundamental justice. A measure cannot be in accordance with the principles of fundamental justice when it is arbitrary. Arbitrariness can be found: (i) when a person's life is put

at risk, and there is no clear connection between the measure chosen and the legislative goals; or (ii) the funding decision is not based on relevant criteria. There is also jurisprudence to show that where the "security of the person interest" is engaged, and the measure would have a disproportionate impact on groups whose equality before the law is guaranteed by section 15, courts should be quite concerned with ensuring that the principles of fundamental justice are applied in a manner consistent with the equality guarantee.

Finally, there can be little doubt that the *Canada Health Act* is focused on curing illnesses. However, this relies on the biomedical definition of disability and ignores the contemporary social model of disablement. Through this oversight, the *CHA* fails to respect equality requirements. In terms of resource allocation, the Supreme Court has held that a constitutional guarantee (notably section 15) can require the provision of a service that, under the statute as passed, was not to be provided. Therefore, governmental spending priorities are *not* an absolute bar to finding that there is a constitutional requirement for the provision of palliative care services. At the very least, the spending priorities of government cannot be discriminatory in nature.

Of course, there can be limits on the scope of the right to palliative care put forward in this paper. The most obvious source of such a limit would be section 1 of the *Charter*. However, the onus would be on the government to justify such limitations. More empirical data is required to obtain a complete picture of the current palliative care delivery system in Canada and, importantly, on the impact of that system on different segments of the Canadian population. Similarly, the impact of changes to palliative care delivery on other government priorities may require further study, both by those who seek to advance the existence of this right and by the government that may seek to define its scope.

Although the focus of this paper has been the *Charter*, this is not the only possible avenue of enforcing human rights, including one to palliative care in Canada. Other Canadian human-rights legislation[197] could provide alternative bases for asserting such a right. Furthermore, the interpretation of human-rights legislation may be influenced by international human rights instruments to which Canada is a signatory. Therefore, notwithstanding our argument that international palliative care developments may not be relevant to establishing a

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[197] All provinces and territories, as well as the Federal Government, have adopted human rights codes or other legislation. See e.g. *Canadian Human Rights Act*, SC 1976-77, c 33, s 2, reprinted in RSC 1985, c H-6; Québec's *Charter of human rights and freedoms*, *supra* note 61; *The Saskatchewan Human Rights Code*, SS 1979, c S-24.1; *The Yukon Territories' Human Rights Act*, RSY 2002, c 116.

Canadian human right to palliative care, the principle of recognition of international obligations might be argued by some to represent a "floor" of rights and protections. At minimum, the existence of these international obligations, along with domestic human rights legislation and codes, provide additional incentive and opportunity to explore and reinvigorate initiatives with respect to a right to equal and meaningful access to palliative care.

The authors believe that the impact of international instruments and domestic human rights legislation deserve robust analysis independent of *Charter* considerations. In order to keep this paper within manageable bounds for both the authors and the reader, a detailed analysis of the non-constitutional legislative framework for the protection of human rights must be left to another day.

In the end, this paper offers one approach which, if adopted, might alter the parameters under which palliative care is made available to Canadians. It is the hope of the authors that this article will stimulate debate on this important issue, among policy-makers, academics, families, caregivers, and the general public. With time and effort on the part of all concerned, better solutions may be found to ensure that end-of-life care needs can be met in a way that affirms the relief of suffering as a defining element of Canadian human rights.

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