The Canadian Medical Association has advised physicians that, in certain circumstances, it may not be unethical for them, without the patient's consent, to disclose to the patient's spouse or current sexual partner AIDS-related information concerning the patient. The legal position of a physician considering making such disclosure is somewhat uncertain: the physician clearly owes a duty of confidence to his or her patient but is there an overriding duty to warn a third party at risk of infection? No completely satisfactory resolution is possible. However, this article submits that, in the absence of legislation authorizing or requiring such disclosure, policy considerations compel the conclusion that such disclosure is illegal.

L’Association médicale canadienne a fait savoir aux médecins qu’ils pouvaient, dans certaines circonstances, révéler à la femme, au mari ou au partenaire sexuel d’un malade, sans l’accord de celui-ci, des renseignements sur le SIDA dont le malade est atteint, et ce sans enfreindre l’éthique professionnelle. La position du médecin ayant en vue de faire ce genre de révélation est plutôt imprécise en droit: il est clair que le médecin est obligé au secret envers son

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malade, mais a-t-il une obligation plus importante, celle d'avertir un tiers qui risque d'être infecté? Aucune solution n'est tout à fait satisfaisante. L'auteur de cet article soutient cependant qu'en l'absence de textes législatifs autorisant ou imposant ce genre de révélation, on est bien obligé de convenir que cette révélation est illégale.

Introduction

The patient is a married bisexual man whose wife is unaware of his bisexuality. He has tested HIV seropositive.\textsuperscript{1} His physician suggests that he should disclose this to his wife. The patient indicates that he will not do this and does not consent to the physician making disclosure. The physician reasonably believes that the patient and his wife do not practise "safe sex"\textsuperscript{2} and that the patient will not suggest to his wife that they begin doing so. Further, the physician has no actual knowledge of the serostatus of the patient’s wife. The physician therefore reasonably believes that the patient’s wife may be at risk of being infected with HIV. (She may already be infected). The physician is considering contacting the patient’s wife to advise her of her husband’s HIV seropositivity. What is the position of the physician ethically and legally?

The Code of Ethics of the Canadian Medical Association requires that a physician keep in confidence information derived from his or her patient and divulge such information only with the permission of the patient or if required to do so by law.\textsuperscript{3} However, at its 1987 annual meeting, the Association resolved that it is not unethical for a physician

\textsuperscript{1} I use "HIV" to refer to the virus called Human Immunodeficiency Virus, which causes acquired immune deficiency syndrome ("AIDS"). Unless a distinction is made in the text or Tables among AIDS, ARC (AIDS related complex) and HIV seropositivity, for convenience I use "HIV seropositive patient" to include a patient who has AIDS, ARC or, while not suffering from either AIDS or ARC, has detectable antibodies to HIV. All HIV seropositive persons are currently presumed to be infectious. A person is "HIV seronegative" if he or she is not HIV seropositive. I use "serostatus" to refer to the condition of a person's blood as either infected or uninfected. See Royal Society of Canada, AIDS: A Perspective for Canadians (Summary Report and Recommendations) (1988), pp. 1-3; and Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic (Washington, D.C., June 24, 1988), Appendix J. I am grateful to Professor George P. Smith II, of the Columbus School of Law, Catholic University of America, for providing me with a copy of this Report. For an excellent introduction to medical information concerning AIDS, see P René et al., Medical Aspects, in D. Snowden and D.F. Cassidy (eds.), AIDS: A Handbook for Professionals (1989).


\textsuperscript{3} The Canadian Medical Association Code of Ethics, Rule 6 states: "An ethical physician will keep in confidence information derived from his patient, or from a colleague, regarding a patient and divulge it only with the permission of the patient except when the law requires him to do so."
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to '‘make discrete disclosure to an appropriate person with the patient’s knowledge’', but without his or her consent, of the fact that the patient has tested HIV seropositive "when [the] public interest [in such disclosure] clearly outweighs the interest of the patient’’. While not becoming part of the Association’s Code of Ethics, this statement was intended as an interpretative guideline for members of the profession.

Not surprisingly, AIDS was again on the Association’s agenda at its 1988 annual meeting. Decisions made at that meeting were incorporated into A CMA Position: Acquired Immunodeficiency Syndrome, published on January 1, 1989. While the Association ‘‘stresse[d] the need to respect the confidentiality of patients with HIV infection and . . . recommend[ed] that legal and regulatory safeguards be put into place to protect such confidentiality’, it advised physicians, that disclosure to a spouse or current sexual partner may not be unethical and, indeed, may be indicated when physicians are confronted with an HIV-infected patient who is unwilling to inform the person at risk. Such disclosure may be justified when all of the following conditions are met: the partner is at risk of infection with HIV and has no other reasonable means of knowing of the risk; the patient has refused to inform his or her sexual partner; the patient has refused an offer of assistance by the physician to do so on the patient’s behalf; and the physician has informed the patient of his or her intention to disclose the information to the partner.


6 Ibid., at p. 650.


8 Ibid., at p. 64B.

9 Ibid. On June 29, 1988, the American Medical Association’s House of Delegates adopted a resolution regarding physicians warning sexual partners of HIV seropositive patients, which states in part:

Ideally, a physician should attempt to persuade the infected party to cease endangering the third party; if persuasion fails, the authorities should be notified; and if the authorities take no action, the physician should notify and counsel the endangered third party. In some states, strict confidentiality laws may limit the exercise of this duty by reason of severe penalties for any breach of confidentiality, especially HIV-related information. Special legislation is needed in these states in order to grant a physician legal immunity to act in the following ways: the legal right to notify directly; or the option of notifying public authorities, or the choice of not acting at all if, in the physician’s judgment, the danger to the third party is seen to fall short of substantial risk. (Emphasis added).

I am grateful to Miss B.J. Anderson, General Counsel to the American Medical Association, for providing me with this information. See also AIDS Beats Hippocrates, Time, July 11, 1988, at p. 21, which suggests that the ‘‘[American Medical Association] may . . . have had in mind a few lawsuits that have been filed seeking damages from physicians who did not warn partners of AIDS victims’’. 
In this article I consider the legal position of a physician faced with the decision whether to disclose to a sexual partner or intravenous drug sharer of a patient (the "partner")10 that the patient is HIV seropositive. I assume that the patient has advised the physician that he or she neither intends to disclose this fact to his or her partner nor consents to the physician making such disclosure, and that the physician reasonably believes that the partner may be at risk of being infected with HIV. If the physician discloses the patient’s HIV seropositivity to the partner without the consent of the patient, is the physician liable to the patient for a breach of confidence? If the physician does not make such disclosure, is the physician liable to the partner for breach of a duty to warn if the partner becomes infected with HIV?

I. The Duty of Confidence

It is clear law that a physician owes a duty of confidence to his or her patient.11 This duty is recognized at common law,12 in at least two provinces by legislation13 and may even be constitutionally guaranteed.14 In

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10 While Canadian Medical Association, A CMA Position, loc. cit., footnote 4, refers only to spouses and sexual partners. I submit that intravenous drug sharers should be considered similarly, since reference to both sexual partners and intravenous drug sharers emphasizes that there are modes of HIV transmission other than sexual activity: see infra, the text accompanying footnote 89.


addition, a physician is specifically required by statute in most provinces and territories not to disclose patient information concerning communicable diseases, including AIDS (see Table A\textsuperscript{15}). The policy underlying the physician’s duty of confidence is obvious: patients must be encouraged to seek treatment without fear that their ailment, condition or treatment will be disclosed.\textsuperscript{16} Encouraging patients to come forward and seek treatment benefits not only patients themselves but also others who may be at risk of infection; that is, maintaining the patient’s confidence is not only in his or her interest but also in the public interest.\textsuperscript{17}

Vehicles for recovery by a patient alleging a breach of this duty include common law actions in contract and negligence and the equitable action in breach of confidence.\textsuperscript{18} Another possible route to recovery is an action alleging a violation of a right to privacy, guaranteed either at common law\textsuperscript{19} or under legislation.\textsuperscript{20} While there is no legislation specifically providing a remedy to a patient whose confidence has been any particular case is not necessarily clear: in this regard, see L. Ducharme, Le secret médical et l’article 9 de la Charte des droits et libertés de la personne (1984), 44 R. du B. 955.


\textsuperscript{15} See Table A, infra, p. 255.

\textsuperscript{16} See Carter v. Carter (1974), 53 D.L.R. (3d) 491, at p. 494, 6 O.R. (2d) 603, at p. 606 (Ont. S.C.); Tarasoff v. Regents of the University of California, 131 Cal. Rptr. 14, at p. 26, 551 P. (2d) 334, at p. 346 (Sup. Ct., 1976); People v. Calvo, 432 N.E. 2d 223, at p. 224 (Ill. Sup. Ct., 1982); Grattan v. People, 477 N.Y.S. 2d 881, at p. 882 (Sup. Ct. App. Div., 1984); X. v. Y, [1988] 2 All E.R. 648, at pp. 651-653, 656 (Q.B.D.); Report of the Presidential Commission, op. cit., footnote 1, p. 126, which states: “Rigorous maintenance of confidentiality is considered critical to the success of the public health endeavor to prevent the transmission and spread of HIV infection. Current public health strategies for fighting the spread of HIV infection are entirely dependent on voluntary cooperation. To encourage individuals to come forward voluntarily for necessary testing, counseling, and treatment, our health care system must be viewed with confidence and trust by those in need of its services. Individuals entering the system must be convinced that information about their health will be kept confidential by those in the system. Aside from the illness itself, it is discrimination that is most feared by the HIV-infected. An effective guarantee of confidentiality is the major bulwark against that fear.” The Report does, however, recommend exceptions to that confidentiality: see footnote 119, infra.

\textsuperscript{17} X. v. Y, supra, footnote 16, at pp. 651-653, 656.


\textsuperscript{19} Rodgers-Magnet, ibid., pp. 265, 288-290.

\textsuperscript{20} See, for example, The Privacy Act, R.S.B.C. 1979, c. 336, s. 1(1); Wooding v. Little (1982), 24 C.C.L.T. 37 (B.C.S.C.); A. Stewart, A. Soltan and K. Thorne, Acquired Immunodeficiency Syndrome—“AIDS” “The Legal Issues Are Also Frightening” (1988), 46 The Advocate 49, at p. 53.
breached, the physician's breach of a statutory obligation of confidentiality may be evidence of negligence; an action for statutory breach *per se* is not available.\(^{21}\) In addition, if the disclosure was untruthful, an action in defamation may lie against the physician.\(^{22}\) Despite the existence of these potential vehicles for recovery, the patient may in fact have considerable difficulty fitting his or her case into a recognized cause of action.\(^{23}\) Indeed, it appears that only one patient in Canada alleging breach of confidence by a physician has obtained relief.\(^{24}\) This suggests a less than wholehearted commitment by the courts to protection of the patient's confidence and, given the evidence of violations of patient confidentiality,\(^{25}\) clearly indicates that existing remedies for a breach of such confidentiality are frequently illusory.\(^{26}\) In response to this situation, legislation specifically providing a remedy for a patient whose confidence has been breached has been recommended.\(^{27}\)

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\(^{21}\) While the existence of a nominate tort of statutory breach has in general been rejected in Canada (breaches of industrial standards legislation being a possible exception), proof of a breach of criminal or quasi-criminal legislation which is causative of damages to a third person may be evidence of negligence: *R. in Right of Canada* v. *Saskatchewan Wheat Pool*, [1983] 1 S.C.R. 205, at pp. 227-228, (1983), 143 D.L.R. (3d) 9, at p. 25, per Dickson J. for the court.

\(^{22}\) Rodgers-Magnet, in *Steel and Rodgers-Magnet*, *op. cit.*, footnote 18, pp. 279-283.

\(^{23}\) Rodgers-Magnet, *ibid.*, p. 267, describes this difficulty as "the failure of the common law to adequately meet the demands of the problem of the protection of the confidentiality of medical information".

\(^{24}\) In *Mammone v. Baken*, the British Columbia Supreme Court, Vancouver Registry, No. C865060, February 10, 1989. unreported, Wood J. awarded the plaintiff patient $1000 damages (described by his Lordship as "more than nominal") against the defendant physician because he had inadvertently disclosed information concerning his treatment of the plaintiff. This was held to breach "an implied term of the contract" between them. Presumably, the implied term referred to was one requiring the physician to maintain his patient's confidence. I am grateful to Mr. Daniel J. McLaughlin, Second Year Law, University of Victoria, 1988-89, for bringing this decision to my attention. Picard, *op. cit.*, footnote 14, p. 23, draws the inference that Canadian courts have only "paid lip service to the right to have medical information kept confidential".


A physician may, however, disclose patient information with the consent of the patient, if authorized or required by statute, or if required "as a matter of public policy".

I have assumed that the patient does not consent to the physician disclosing his or her HIV seropositivity. Therefore, in order for the physician to make such disclosure legally, it must be authorized or required by statute or required as a matter of public policy. While all provinces and territories have legislation requiring physicians to report AIDS-related patient information to medical health officers, there is no AIDS-specific Canadian legislation specifically requiring or authorizing disclosure by a physician of such information to a partner of the patient. In contrast, for example, California has recently enacted AIDS-specific legislation which authorizes, but does not require, disclosure by a physician of a patient's HIV seropositivity to his or her spouse. However, there is legislation in some Canadian jurisdictions requiring or authorizing disclosure by a physician of patient information if such disclosure is necessary to protect a third party. Although such legislation is not AIDS-specific, it does in some cases encompass disclosure of AIDS-related patient information. There are three different legislative situations in Canada.


29 See Picard, ibid., pp. 16-17; R. Sharpe, The Law and Medicine in Canada (2nd ed., 1987), pp. 184-191. In Simonsen v. Swenson, 177 N.W. 831, at p. 832 (Neb. Sup. Ct., 1920), Flansburg C., for the court, stated: "When a physician, in response to a duty imposed by statute, makes disclosure to public authorities of private confidences of his patient, to the extent only of what is necessary to a strict compliance with a statute on his part, and when his report is made in the manner prescribed by law, he of course has committed no breach of duty toward his patient, and has betrayed no confidence, and no liability could result."

30 See Picard, ibid., pp. 19-21; Sharpe, ibid., pp. 181-183. I mention that the authority cited in support of this statement is often case authority in which there was in fact some statutory reporting duty. Examples of cases which did involve consideration of disclosure "as a matter of public policy" or "in the public interest" are Furniss v. Fitchett, supra, footnote 12, at pp. 405-406; Tarasoff v. Regents of University of California, supra, footnote 16, at pp. 26-27 (Cal. Rptr.), 560-561 (P).

31 See Table B, infra, pp. 256-257.

32 California Health and Safety Code, s. 199.25, provides: "Notwithstanding any provision of law, no physician and surgeon who has ordered a test to detect antibodies to the probable causative agent of acquired immune deficiency syndrome and who has the results of the test shall be held criminally or civilly liable for disclosing to a person believed to be the spouse of a patient that the patient has tested positive on a test to detect antibodies to the probable causative agent of acquired immune deficiency syndrome. This section is permissive on the part of the attending physician."
First, the Yukon Territory has legislation which requires a physician who "has reason to believe or suspect" that a patient "is infected with a communicable disease" to disclose this to "any known contacts" of the patient.\(^{33}\) AIDS, but neither ARC nor HIV seropositivity, has been declared a communicable disease.\(^{34}\) It is clear that a physician who believes or suspects that a patient has AIDS must disclose this to known contacts of the patient. However, in view of the use of "suspect" and "infected" in the legislation and the apparent practice in at least one province, admittedly in a different context, of interpreting "AIDS" as encompassing ARC and HIV seropositivity in addition to AIDS per se,\(^{35}\) it is open to question whether a physician is also required to disclose to contacts that a patient has ARC or is HIV seropositive. In the Northwest Territories, a physician who "has received a positive test result for one of his patients or . . . has reason to believe or suspect that one of his patients is infected with a communicable disease . . . shall . . . in accordance with guidelines provided by the Chief Medical Health Officer, carry out contact tracing or surveillance of those aspects of the occurrence and spread of the communicable disease that are pertinent to the effective control of the disease, or . . . request the Chief Medical Health Officer to carry out the contact tracing or surveillance".\(^{36}\) AIDS and HIV seropositivity are listed as reportable communicable diseases in the Northwest Territories; however, since HIV infection is a prerequisite to a diagnosis of ARC, in effect all of AIDS, ARC and HIV seropositivity are reportable.\(^{37}\) Therefore, the physician is required either to make disclosure concerning AIDS, ARC or HIV seropositivity directly to the patient's contacts or request the Chief Medical Health Officer to do so. A physician in the Northwest Territories who in good faith chooses to make disclosure directly to the patient's contacts rather than requesting the chief medical health officer to do so, is specifically protected by legislation from liability in respect of the breach of confidence.\(^{38}\) While no similar specific provision exists

\(^{33}\) The (Yukon) Communicable Diseases Regulations, Y.T. Reg. 1961/48, s. 5(1), as amended by Y.T. Reg. 1970/46, provides that: "Every medical practitioner who has reason to believe or suspect that one of his patients is infected with a communicable disease shall advise such patient . . . and any known contacts . . . to adopt the specific control measures for such disease and shall give them the necessary instructions therefor." (Emphasis added).

\(^{34}\) The (Yukon Territory) Public Health Act, R.S.Y.T. 1986, c. 136, Schedule I, as annexed by O.I.C. 1987/214.

\(^{35}\) In Ontario the physician's obligation to report to a medical health officer that a patient has "AIDS" appears to be interpreted as requiring the physician to report cases of ARC and HIV seropositivity as well. I emphasize that such an interpretation is not possible at least in British Columbia. See footnote 2 to Table B, infra, p. 257.


\(^{37}\) See Table B, infra, pp. 256-257.

\(^{38}\) The (Northwest Territories) Communicable Diseases Regulations, supra, footnote 36, s. 8.
in the Yukon, the legislation requiring the physician to make disclosure to the patient's contacts would clearly afford a good defence if the patient claimed in respect of the breach of confidence. If, however, a physician does not make disclosure to a partner, the partner will recover against the physician only if the physician is held to have owed a common law duty to warn since the legislation does not provide a remedy to the partner. The physician's breach of the statutory obligation to disclose to contacts of the patient or request that a medical health officer do so may, however, be evidence of a breach of a common law duty to warn.

Second, Prince Edward Island has legislation which clearly authorizes, but does not require, a physician to disclose to "members of the [patient's] family" that a patient has AIDS or is HIV seropositive. Again, this legislation would necessarily also encompass patients who have ARC. Alberta and Manitoba have legislation which, with ministerial approval, authorizes disclosure of confidential patient information concerning communicable or sexually transmitted diseases respectively. This encompasses patient information concerning AIDS, but neither ARC nor HIV seropositivity. Therefore, subject again to the difficulty with interpreting "AIDS", this legislation may authorize a physician to disclose AIDS-related patient information with ministerial approval.

39 See the text at footnote 29, supra.
40 Supra, footnote 21.
41 The Public Health Act Notifiable and Communicable Diseases Regulations, R.R.P.E.I. 1987, Reg. E.C. 330/85, s. 14, provides: "A physician . . . may give information concerning the condition of a person who is or is suspected of being infected with a notifiable or other regulated disease to members of the person's family for the protection of their health." (Emphasis added). AIDS and "HIV antibodies" are notifiable diseases: The Public Health Act Notifiable and Communicable Diseases Regulations, R.R.P.E.I. 1987, P.E.I. Reg. EC30/85, s. 17, as amended by P.E.I. Reg. EC 409/87. These provisions would seem to constitute an exception to the confidentiality imposed by The Public Health Act, S.P.E.I. 1980, c.42, s. 22(1), particularly in view of the provisions of s. 22(2) of the Act itself.
42 The Public Health Act, S.A. 1984, c. P-27.1, s. 63(5)(b), provides that confidential patient information about communicable disease may be disclosed "to any person with the written consent of the Minister, where in his opinion it is in the public interest that the information be disclosed to that person". (This is an exception to the confidentiality of patient information concerning communicable diseases imposed by sections 63(1) and 63(3) of the Act.) AIDS is prescribed as a communicable disease: The Public Health Act Communicable Diseases Regulation, Alta. Reg. 238/85, Schedule I. In Manitoba, The Public Health Act Diseases and Dead Bodies Regulation, R.R.M. 1971, Reg. P210-R2, s. 48(b) provides that confidential patient information about sexually transmitted diseases may be disclosed "upon the written instruction of the Minister". (This is an exception to the confidentiality of patient information concerning sexually transmitted diseases imposed by section 48 of the Regulation.) AIDS is a reportable sexually transmitted disease: The Public Health Act Diseases and Dead Bodies Regulation, R.R.M. 1971, Reg. P210-R2, s. 5, as amended Man. Reg. 139/87, s. 1. Quaere, however, whether these provisions apply only to government employees, as opposed to independent physicians. Section 48 of the Manitoba Regulation applies to "person[s]
bec has disclosure authorizing legislation but it does not, however, encompass disclosure of AIDS-related patient information. Therefore, Quebec is included in the third category below. Despite the difference between legislation requiring disclosure and that merely authorizing disclosure, the position of the physician under the latter is substantially the same as under the former. If the physician disclosed the patient’s HIV seropositivity, the legislation authorizing such disclosure probably affords a defence to any claim by the patient alleging a breach of confidence. Admittedly this defence is not as certain as under legislation requiring disclosure. If the physician did not make disclosure and the partner claims against the physician, the issue again is whether the physician breached a common law duty to warn. Since the legislation merely authorized disclosure, the physician did not breach it in failing to warn the partner. However, while there is no statutory breach affording evidence of negligence, the existence of the disclosure authorizing legislation may be considered by a judge in balancing the physician’s duty of confidence to the patient and the partner’s claim to be warned. In passing, I mention that Ontario repealed a similar disclosure authorizing provision which had been applicable to patient information concerning venereal diseases.

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Engaged in the administration of this Division [of the Regulation]”. Section 63 of the Alberta Act applies to any person.

43 The Code of Ethics of Physicians, R.R.Q. 1981, c. M-9, R.4, s. 3.04. provides that: “The physician may . . . reveal facts which have come to his personal attention . . . if there should be a just and imperative motive related to . . . the welfare of others [than the patient].” (Emphasis added). However, The Public Health Protection Act, R.S.Q. 1977, c. P-35, s. 7, provides that information permitting identification of a person named in a report concerning a declarable disease “shall only be divulged to that person” and that “this provision takes priority over every other provision of any general law or special act”. (Despite its marginal notation “privileged information”, this section deals with both privilege and confidence; see supra, footnote 11). AIDS is declarable: The Public Health Protection Act Regulation, R.R.Q. 1981, c. P-35, r. 1, s. 28(b), as amended by O.C. 1497/86. I am assuming that if information concerning a patient having AIDS may only be divulged to him or her, the same rule applies to a patient who has ARC or is HIV seropositive.

44 I emphasize that only civil consequences are under consideration here. A physician who fails to comply with legislation requiring disclosure may commit a quasi-criminal offence (see The (Northwest Territories) Public Health Ordinance, R.S.N.W.T. 1974, c. P-10, s. 23; The (Yukon Territory) Public Health Act, R.S.Y.T. 1986, c. 136, s. 20), whereas no offence is committed if legislation merely authorizes disclosure.

45 See the text accompanying footnote 29, supra.

46 The Venereal Diseases Prevention Act, R.S.O. 1980, c. 521, s. 13(3) provided that “. . . a physician may give information concerning the patient to other members of the patient’s family for the protection of health”. This Act was repealed by The Health Protection and Promotion Act, 1983, S.O. 1983, c. 10, s. 111(3). Section 38(1) of the latter Act makes patient information concerning communicable, reportable or virulent diseases confidential and the exceptions to that confidentiality listed in section 38(2) do not provide for any exception analogous to the provisions of section 13(3) of the former Act.
Third, in all other provinces, that is, in British Columbia, New Brunswick, Newfoundland, Nova Scotia, Ontario, Quebec and Saskatchewan, there is no legislation either requiring or authorizing a physician to disclose AIDS-related patient information to a patient’s partner. In these provinces, the relationship between the competing claims of the patient to the duty of confidence and the partner to a duty to be warned must be determined by reference to the common law and legislation requiring that patient information concerning communicable diseases be kept confidential.

In summary:

1. Patient’s claim to confidence:
   a. legislation either requiring or authorizing disclosure by a physician to a patient’s partner of AIDS-related patient information affords the physician a defence to a claim by the patient in respect of an alleged breach of confidence;
   b. in the absence of such legislation, the patient’s claim in respect of an alleged breach of confidence must be determined by reference to the common law and legislation requiring that patient information concerning communicable diseases be kept confidential; and

2. Partner’s claim to warning:
   in all three situations, whether the physician owes the partner a duty to warn must be determined at common law by asking whether such an exception to the duty of confidence is required “as a matter of public policy”; however, legislation either requiring or authorizing disclosure may provide evidence of a common law duty to disclose owed to the partner.

II. A Duty To Warn?

In Rivtow Marine Ltd. v. Washington Iron Works, the Supreme Court of Canada held that the manufacturer and supplier of a crane owed a

47 The Nova Scotia Task Force, op. cit., footnote 27, pp. 69-70, has recommended that “[p]rovincial legislation should provide that, where a physician has a bona fide belief that an HIV-infected person may be dangerous to others, and that disclosure of the patient’s HIV status may minimize or prevent this threat, the physician may disclose such information to the person or persons in danger... without the consent of the patient and disclosure made under such a belief shall be considered privileged and shall not amount to professional misconduct”.

48 See the text at footnote 43, supra.

49 I use “common law” to refer to case precedent and not common law as distinguished from civil law. See the text accompanying footnote 52, infra.

50 See Table A, infra, p. 255.

duty to warn the charterer of the crane of a defect in it which threatened physical harm to persons and property. This decision clearly supports the existence of a general duty to warn of a known risk of physical harm to persons or property. Such an obligation would also seem to be part of the civil law of Quebec. However, the fact situation in Rivtow Marine was significantly different from the problem under consideration since it did not involve a conflicting duty of confidentiality.

In Tarasoff v. Regents of University of California, the Supreme Court of California did face such a situation. The facts were that a patient had confided to his psychologist that he intended to kill a named woman. The psychologist did not warn her and, two months later, the patient fatally shot and stabbed her. The majority of the court considered the psychologist’s defence based on his duty of confidence to his patient, but held that he had been under a duty to warn the woman, her family or the police, a duty which prevailed over his duty of confidence. This conclusion, originally limited to situations involving a threat of violence against a specific victim but subsequently extended to risks that endangered persons closely associated with the person threatened and even unidentifiable but foreseeable persons, may well be part of Canadian law.

A judge assessing the reasonableness of a physician’s failure to warn an HIV seropositive patient’s partner (I am assuming that the partner has suffered injury—HIV infection, AIDS, or death—and that factual and proximate causation between the failure to warn and the injury can be established) would consider whether the risk to the partner was sufficiently analogous to that in Tarasoff to make the reasoning and con-

52 J.-L. Baudouin, La Responsabilité civile délictuelle (1985), pp. 60-61, states that responsibility for wrongful omissions ("fautes d’omission") derives from the general duty imposed by article 1053 of the Civil Code of Lower Canada, which provides that "[e]very person capable of discerning right from wrong is responsible for the damage caused by his fault to another, whether by positive act, imprudence, neglect or want of skill".

53 Supra, footnote 16.


59 See Picard, op. cit., footnote 14, pp. 19-20, and Tanner v. Norys, [1980] 4 W.W.R. 33 (Alta. C.A.), in which the facts were not similar to the problem under consideration in this article but which referred to Tarasoff with approval.
clusion of that decision applicable. Analogies between the risks would
be argued. An HIV seropositive patient might be considered a specific
threat to a specific partner. Referring to the broader interpretation given
by some courts to Tarasoff, a physician should certainly foresee that
partners of HIV seropositive patients may be at risk of HIV infection.
Further, just as the patient in Tarasoff threatened to commit a criminal
act, so too an HIV seropositive patient arguably commits a criminal act
if he or she engages in activity with a partner which may result in HIV
transmission, whether or not HIV is in fact transmitted. The possibility
that an HIV seropositive patient may not continue to engage with a
partner in activity which may result in HIV transmission does not nec-
essarily indicate that Tarasoff is distinguishable, since the patient in Tarasoff
might equally have not carried out his threat of violence. Indeed, the
Supreme Court of California was aware of this possibility. Tobriner J.
stated, however, “that professional inaccuracy in predicting violence can-
not negate the therapist’s duty to protect the threatened victim”.

However, the risk that the patient may infect the partner with HIV
is significantly different from the risk that the victim in Tarasoff might
be attacked, injured or even killed since it is possible, perhaps even
probable depending upon the circumstances, that the risk has already
materialized before the physician becomes aware of the patient’s HIV
seropositivity. That is, the partner may already be HIV seropositive. If
this is in fact the situation, the partner would have no claim against the
physician for a failure to warn since there would be no causal connec-
tion between that failure to warn and the partner’s HIV seropositivity.
Even if this is not the situation, a judge would take into account that this
possibility was one of the unknowns facing the physician when he or
she decided not to warn.

60 See the text accompanying footnotes 57-58, supra.
61 In particular, the provisions of the Criminal Code, R.S.C. 1985, c. C-46, ss.
219-221, might apply to an HIV transmission. If HIV is not transmitted, the patient may
be liable for attempting to commit a criminal act: Criminal Code, ibid., s. 24. See M.
MacKinnon, K. Cottrelle and H. Krever, Legal and Social Aspects of AIDS in Canada,
in Royal Society of Canada, AIDS: A Perspective for Canadians (Background Papers)
(1988), op. cit., footnote 1, p. 355; L. Ducharme, Preparing for a Legal Epidemic: An
A man who donated blood to the Red Cross, allegedly despite knowing that he was HIV
seropositive, has recently been charged with committing a common nuisance contrary to
But see Ducharme, ibid., at p. 492. Another man, accused of knowingly transmitting
HIV to a pregnant woman, has been committed to stand trial on a charge of criminal

62 See the text accompanying footnote 89, infra.
63 Tarasoff v. The Regents of the University of California, supra, footnote 16, at
pp. 26 (Cal. Rptr.), 346 (P).
Assuming that an HIV seropositive patient continues to engage with a partner in activity which may result in HIV transmission, which is analogous to the patient in Tarasoff carrying out his threat of violence, it is arguable that there are also significant differences between the injury which resulted in Tarasoff and that which may result here. First, the probabilities of injury occurring may be different. The probability that the victim in Tarasoff would be attacked violently, if the patient acted, and die immediately or soon after the attack was high. In comparison, the probability of HIV infection in at least one of the modes of HIV transmission, namely vaginal intercourse, is low for each act of intercourse and becomes high only after hundreds of acts of intercourse. Vaginal intercourse is likely the most relevant, if not only, possible mode of HIV transmission between the hypothetical patient and his wife. Hundreds of acts of intercourse would be typical. Further, a partner infected with HIV (by whatever mode of transmission) stands about a thirty-five per cent chance of developing AIDS within seven years and, if AIDS develops, will probably die within two years. Perhaps most signifi-

64 There is no general agreement yet as to the probability of HIV transmission during activity identified as modes of transmission. With respect to the probability of HIV transmission during sexual activity, the following distinctions must be made. Is the activity homosexual or heterosexual? If intercourse is involved, is it vaginal, oral or anal? Is the infected partner the male or the female? (There is at least some data suggesting that male-to-female transmission is more probable than female-to-male transmission: Hearst and Hulley, loc. cit., footnote 2, at p. 2429). There is, however, general agreement that AIDS has a much lower infectivity rate than other sexually transmitted diseases and that, in particular, the probability of HIV transmission is low in vaginal intercourse: see J. Levy, The Transmission of AIDS: The Case of the Infected Cell (1988), 259 Jo. Am. Med. Ass. 3037, at p. 3037. Indeed, one report estimates that the probabilities of HIV infection during "penile-vaginal intercourse" are 1 in 5 billion for a single sexual encounter using a condom with a partner who is known to be HIV-seronegative (infection by a partner known to be HIV seronegative is a possibility since false test results are possible) and who is not in a high-risk group (high-risk groups being defined in the report as homosexuals, bisexuals, intravenous drug users from major metropolitan areas and hemophiliacs); 1 in 500 for a single sexual encounter not using a condom with a partner who is known to be HIV-seropositive; and 2 in 3 for 500 sexual encounters with a known HIV-seropositive partner and not using condoms. See Hearst and Hulley, supra, at p. 2429. See also Ducharme, loc. cit., footnote 61, at pp. 507-509.

65 Hearst and Hulley, ibid., at p. 2430.

66 Royal Society of Canada, op. cit., footnote 1, p. 3, states: "Although there is still disagreement as to the overall risk of HIV-infected persons developing AIDS, various ongoing follow-up studies show that 10% develop AIDS within four years of infection and 35% within seven years. These figures vary according to risk group. Many observers believe that the risk continues throughout life and that all those infected will eventually develop AIDS."

67 Royal Society of Canada, ibid., p. 4, states: "After diagnosis, 52% of [AIDS] patients die within one year and 74% within two years." However, a very small percentage of AIDS patients are alive years after diagnosis: see, Surviving Is What I Do, Time, May 2, 1988, pp. 58-59, which refers, inter alia, to intervention with the experimental drug AZT.
cantly, the partner may already be HIV seropositive, in which case the probability of injury is zero. Second, the gravity of the injury suffered by the partner may differ from that suffered by the victim in Tarasoff. The partner may be infected with HIV but otherwise remain perfectly healthy. While possibly having claims in respect of mental suffering and loss of enjoyment of life, the partner’s injuries may be considered less grave than those of the victim in Tarasoff. On the other hand, if the partner suffered for years with AIDS and eventually died, his or her injuries may be considered more grave. Of course, the losses actually suffered by the partner are irrelevant on the initial question of whether the physician is liable for the failure to warn. However, the nature of the injuries possible is a factor which a judge would consider in assessing the physician’s conduct. Third, the nature of the act which causes harm is fundamentally different since sexual activity and drug sharing are consensual whereas violent attack is not. For these reasons, I submit it is uncertain how a judge would compare the injury in Tarasoff with those possible here.

In short, it is unclear whether a judge considering a partner’s claim to be warned would apply Tarasoff.

Case authority which initially appeared more directly germane because it asserts or is cited for the existence of a duty owed by a physician to warn a third party of the risk of infection by his or her patient nevertheless frustrated my hope of finding guidance since, while making statements about warning of a risk of infection, most of these cases involved fact situations quite dissimilar to the problem under consideration.

68 This assumes that there is no treatment for HIV seropositivity (which is currently the case) and therefore no benefit to the HIV-seropositive partner who is made aware of his or her seropositivity by a warning from the patient’s physician. Quaere, however, whether possible immunomodulation through medication or lifestyle change or intervention with AZT affects this assertion.

69 If the physician is held liable, the partner’s actual injuries become relevant, and indeed determinative, on the subsequent assessment of damages.

70 I am using “consensual” simply to refer to mutual consent to sexual activity or intravenous drug sharing. In particular, I am assuming that the hypothetical patient and his wife mutually consent to sexual activity. The consent to sexual activity or intravenous drug sharing may be vitiated if disease is transmitted and the risk of such transmission had not been disclosed by one partner to the other: see the text accompanying footnote 121, infra.

71 As an example of such a case, I use Tarasoff, considered in the text accompanying footnotes 52-69, supra. In the course of his judgment, Tobriner J., for the majority, stated that “[t]he courts hold that a doctor is liable to persons infected by his patient if he negligently . . . fails to warn members of the patient’s family”; supra, footnote 16, at pp. 24 (Cal. Rptr.), 599 (P). However, as indicated, Tarasoff did not on its facts consider whether a duty to warn of the risk of infection with communicable disease could override a duty of confidence owed to a patient. Rather, it involved a duty to warn of the risk of being shot and stabbed. Further, each of the cases cited by Tobriner J. in support
the end, I was able to locate only two cases—one Canadian and one American—which are helpful.

In _C. v. D._, the plaintiff, a young girl, alleged that the defendant physician had slandered her when he advised one of his patients that she had a venereal disease and should not, therefore, continue sharing a bed with the patient’s own daughter. It must be stressed that the plaintiff was not a patient of the defendant. Riddell J. was of the opinion that the defendant had been under a moral, but perhaps not a legal, duty to warn his patient. He stated:

> I am of opinion that any medical man—while there is, or may be, no legal obligation cast upon him to do so—owes a moral duty to those for whom he is family physician to warn them of danger of venereal infection concerning which he has credible information.

Similarly, referring to the communicable disease reporting legislation then in force in Ontario, he emphasized that “[n]one of these Acts specifically makes it the legal duty of a physician to report communicable disease except . . . to the Health Officer.” In the result, Riddell J. held that the defendant had established a defence of qualified privilege since he had had an honest and reasonable belief that the plaintiff was infected with a venereal disease and had acted under a sense of moral duty and without malice. Therefore, the plaintiff’s action was dismissed.

I stress that in this case the defendant physician had not breached any duty of confidence owed to a patient but, on the contrary, was held to have acted in the best interests of a patient, namely the person whom

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of his assertion—_Skillings v. Allen_, 173 N.W. 663 (Minn. Sup. Ct., 1919); _Davis v. Rodman_, 227 S.W. 612 (Ark. Sup. Ct., 1921); _Jones v. Stanko_, 160 N.E. 456 (Ohio Sup. Ct., 1928); _Wojcik v. Aluminium Company of America_, 183 N.Y.S. 2d 351 (N.Y.S.C., 1959)—is distinguishable from the fact situation under consideration in this article on one or more points: (1) third party knew of patient’s disease; (2) no refusal by patient to make disclosure; (3) physician negligently misdiagnosed patient’s illness; (4) physician did not fail to warn third party but rather negligently advised third party that there was no risk of infection; and (5) physician failed to disclose patient’s condition to the patient. _X. v. Y._, _supra_, footnote 16, dealt with a disclosure by an employee of the plaintiff health authority of AIDS-related patient information to a reporter of the defendant newspaper which wished to publish the information. The plaintiff obtained an injunction restraining publication. While of interest, this case is distinguishable from the problem under consideration since, first, the breach of confidence was admitted and, second, the interest in freedom of the press to inform the public that physicians with AIDS are continuing to practice, as claimed by the newspaper, is probably less compelling than the interest of a patient’s partner claiming a right to be warned against a risk of HIV infection.

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73 The plaintiff’s physician was another doctor, a “Dr. S.”: see _C. v. D._, _ibid._, at pp. 737 (D.L.R.), 212 (O.L.R.).
75 _Ibid_. (Emphasis added).
he warned. Moreover, Riddell J. did not have to make a finding as to whether the physician had been under a legal, as opposed to moral, duty to warn.

The relevant American case is Simonsen v. Swenson.76 The plaintiff was working away from his hometown and was staying with other workers at a hotel operated by a Mrs. Bristol. He became afflicted with sores on his body and was examined by the defendant physician, who tentatively diagnosed syphilis, advised him that the disease was highly contagious and told him that he should leave the hotel to avoid communicating the disease to others. The next day the defendant learned that the plaintiff had not left the hotel. The defendant then warned Mrs. Bristol (who along with her family was a regular patient of the defendant) that the plaintiff was afflicted with a "contagious disease" and told her to disinfect articles used by him and fumigate his room. The plaintiff was forced to leave the hotel.

The plaintiff claimed damages for "breach of duty arising from [the] confidential relationship"77 between the defendant as physician and himself as patient, alternatively referred to in the case as "a breach of . . . [a] duty of secrecy",78 the duty being one imposed by statute.79 Flansburg C., for the court, stated:80

\[\text{No patient can expect that if his malady is found to be of a dangerously contagious nature he can still require it to be kept secret from those to whom, if there was no disclosure, such disease would be transmitted. The information given to a physician by his patient, though confidential, must, it seems to us, be given and received subject to the qualification that if the patient's disease is found to be of a dangerous and so highly contagious or infectious a nature that it will necessarily be transmitted to others unless the danger of contagion is disclosed to them, then the physician should, in that event, if no other means of protection is possible, be privileged to make so much of a disclosure to such persons as is necessary to prevent the spread of the disease. A disclosure in such case would, it follows, not be a betrayal of the confidence of the patient, since the patient must know, when he imparts the information or subjects himself to the examination, that, in the exception stated, his disease may be disclosed.}\]

The fact situation in Simonsen v. Swenson is closer to the problem under consideration than was that in C. v. D. The defendant did breach a duty of confidence to a patient when he warned Mrs. Bristol. He was faced with a difficult conflict between the interests of a patient who "was a stranger at the place"81 and persons who were regular patients. Regardless of this distinction, the point is that the defendant warned a

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76 Supra, footnote 29.
77 Ibid., at p. 831.
78 Ibid., at pp. 831-832.
79 Ibid., at p. 832.
80 Ibid. (Emphasis added).
81 Ibid., at p. 831.
patient. Admittedly, Flansburg C.'s statement is broad enough to encompass warning someone who is not a patient of the physician. However, that was not the situation on the facts of the case. From a more doctrinal perspective, I mention that the court held that, since "[a]t common law [in Nebraska] there was no privilege as to communications between physician and patient, and this rule still prevails when not changed by statute", the statute which made a "betrayal of a professional secret" by a physician misconduct had to be "strictly construed".\textsuperscript{82} Canadian law's starting point is different: a duty of confidence is owed at common law.\textsuperscript{83}

One writer has commented on \textit{C. v. D.} as follows:\textsuperscript{84}

No doubt the court balanced the interests in maintaining confidentiality against the risk of spreading infection, with the latter assuming greater importance before antibiotics existed.

It seems quite unlikely that a modern court would decide the case the same way today, given that the public interest in controlling communicable diseases has probably been sufficiently addressed by additional statutory reporting provisions, and in view of the contemporary climate of respect for individual privacy.

I agree and submit that this opinion applies equally to \textit{Simonsen v. Swenson}. However, this point of view is based in part on the fact that there now is a cure for syphilis. There is no cure for AIDS and in this regard it is similar to syphilis in the 1920s. But comparison of syphilis in the 1920s and AIDS today should not be limited to the question of treatment. I submit that the judges who decided \textit{C. v. D.} and \textit{Simonsen v. Swenson} were also motivated to a significant degree by the frightening belief, reasonably based upon the then accepted medical knowledge concerning the modes of transmission of venereal disease, that syphilis could be transmitted by casual contact.

In \textit{Simonsen v. Swenson},\textsuperscript{85} the court proceeded on medical evidence, apparently not in dispute, which was summarized by Flansburg C. as follows:

The testimony of the physicians disclosed that this particular disease is very readily transmitted in its early stages, and could be carried through drinking cups, eating utensils, and other articles handled or used by the diseased person.

Similarly, in \textit{C. v. D.},\textsuperscript{86} Riddell J. referred to the venereal disease in question (never specifically identified but likely syphilis) as being "a communicable disease of a very virulent type"\textsuperscript{87} of which "the danger

\textsuperscript{82} \textit{Ibid.}, at p. 832.
\textsuperscript{83} See the text accompanying footnote 12, \textit{supra}.
\textsuperscript{84} Sharp, \textit{op. cit.}, footnote 29, p. 182.
\textsuperscript{85} \textit{Supra}, footnote 29, at p. 831.
\textsuperscript{86} \textit{Supra}, footnote 72.
\textsuperscript{87} \textit{Ibid.}, at pp. 735 (D.L.R.), 210 (O.R.).
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to the child of infection by sleeping with a woman suffering from... [it] is notorious—'common knowledge'.

In contrast, the medical knowledge with respect to HIV transmission is completely different: it is not spread by casual contact, but rather by very specific modes of transmission. In its recent report, AIDS: A Perspective for Canadians, the Royal Society of Canada stated:

The known routes of HIV transmission are the following:

- By anal intercourse with an infected person;
- By vaginal intercourse with an infected person;
- By using contaminated needles;
- From an infected mother to her infant;
- Via transfusion of infected blood or blood products;
- Via organs transplanted from an infected donor.

As to how HIV is not transmitted, the Surgeon General of the United States has stated:

Everyday living does not present any risk of infection. You cannot get AIDS from casual social contact. Casual social contact should not be confused with casual sexual contact which is a major cause of the spread of the AIDS virus. Casual social contact such as shaking hands, hugging, social kissing, crying, coughing or sneezing, will not transmit the AIDS virus. Nor had AIDS been contracted from swimming in pools or bathing in hot tubs or from eating in restaurants (even if a restaurant worker has AIDS or carries the AIDS virus). AIDS is not contracted from sharing bed linens, towels, cups, straws, dishes, or any other eating utensils. You cannot get AIDS from toilets, doorknobs, telephones, office machinery, or household furniture. You cannot get AIDS from body massages, masturbation or any non-sexual contact.

Similarly, the Royal Society of Canada has stated:

HIV is not transmitted by casual contact, by saliva or respiratory droplets, by insect bites, or by inanimate objects such as toilet seats and drinking glasses. The virus is relatively fragile and dies quickly outside the body. In seven studies, a total of 491 family members of 228 AIDS patients were carefully followed up. These studies failed to show a single instance of HIV infection among household members who did not have additional exposure through blood or sexual activity.

Comparison of the risk of infection with syphilis, as determined in C. v. D. and Simonsen v. Swenson given the then existing medical knowledge, and the risk of HIV infection, assists in assessing the guidance to be derived from those cases. In C. v. D. and Simonsen v. Swenson, it was believed that persons in casual contact with persons suffering from syphilis would be at risk of infection. Similarly, a partner of an HIV

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88 Ibid., at pp. 738 (D.L.R.), 213 (O.R.).
89 Royal Society of Canada, op. cit., footnote 1, p. 3.
91 Royal Society of Canada, op. cit., footnote 1, p. 3.
seropositive patient may be at risk of HIV infection. (On the other hand, he or she may already be infected). However, this initial similarity is not on all fours in two respects. First, the probabilities of infection of persons at risk differ. Whereas medical evidence in the 1920s indicated that syphilis was "very virulent", "so highly contagious or infectious" that persons in casual contact with an infected person would "necessarily" be infected, HIV appears not to be readily transmitted even in at least one of the identified modes of transmission, namely vaginal intercourse.

Second, C. v. D. and Simonsen v. Swenson proceeded on the assumption that the only way in which the party at risk could be protected was by a warning from the physician. Flansburg C. specifically suggested that if "other means of protection [had been] possible", the court might not have held in favour of the defendant physician. It is possible to protect the HIV seropositive patient's partner by means other than a physician's warning. Direct means include a partner's warning, a medical health officer's warning and education about the importance of self protection and personal responsibility. Indirectly, encouragement of voluntary HIV testing through adherence to the physician's duty of confidence may protect partners of HIV seropositive patients in that patients aware of their seropositivity are at least able to warn partners. Admittedly, these means may not protect all partners. In particular, they may not protect the patient's wife in the opening hypothetical. Given these differences between the risk of HIV transmission and that considered in C. v. D. and Simonsen v. Swenson, I submit that the particular results in these cases are not indicative of the conclusion that should be arrived at in the problem under consideration.

Finally, I briefly mention another argument which may be relevant. As indicated, a physician may be required by statute to disclose patient information. Such statutory exceptions to the duty of confidence typically require the physician to report patient information to some official such as, for example, a medical health officer, a police officer, a social worker designated by a child welfare officer or a registrar of motor vehicles, as distinguished from reporting to some third party who may be directly or indirectly affected by the patient's conduct. However, failure by a physician to comply with a statutory duty to report a patient's condition or ailment to the required official may assist a person who has suffered

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92 See the text at footnote 87, supra.
93 See the text at footnote 80, supra.
94 Ibid.
95 See the text at footnote 64, supra.
96 See the text at footnote 80, supra.
97 These concerns are considered below; see the text at footnote 117, infra.
98 The text accompanying footnote 29, supra.
injury because of the patient’s condition or ailment and who claims against the physician in respect of that injury.\textsuperscript{99} Since no Canadian case appears specifically to have arrived at this conclusion, the status of this argument is uncertain.\textsuperscript{100}

Nevertheless, in the context of the problem under consideration, the possibility exists that failure by a physician to comply with a statutory duty to report a patient’s communicable disease to a medical health officer may be evidence of negligence on the part of the physician, if that omission prevented the medical health officer from warning a partner of the patient and if the necessary causal connection between the lack of warning and infection is established.\textsuperscript{101} In particular, physicians in all provinces and territories are required to report various AIDS-related patient information to medical health officers.\textsuperscript{102} If a physician fails to report required information concerning an HIV seropositive patient, a partner who is infected with HIV by that patient may argue that the physician’s failure to report is evidence of negligence on the part of the physician.\textsuperscript{103} This argument is similar to that of a partner who alleges that failure by a physician to disclose AIDS-related patient information to him or her pursuant to legislation requiring or authorizing disclosure constitutes evidence of negligence,\textsuperscript{104} except that that partner’s argument is probably stronger since legislation requiring or authorizing disclosure specifically contemplates persons at risk of infection whereas legislation requiring reporting of patient information to medical health officers only indirectly contemplates such persons. On the other hand, compliance by a physician with the obligation to report to a medical health officer does not necessarily afford a defence to a claim by the partner who was warned neither by the physician nor the medical health officer and who now alleges that the physician breached a duty to warn him or her. However, I submit that the physician’s compliance with the statutory reporting obligation may be evidence of absence of negligence, just as evidence of the breach of a statutory provision may be evidence of negligence.

\textsuperscript{99} In general, if the physician’s breach of the duty of confidence involved a breach of a statutory obligation, this fact may assist the patient in recovering damages: \textit{Simonsen v. Swenson}, supra, footnote 29, at p. 832; \textit{Munzer v. Blaisdell}, 49 N.Y.S. 2d 915 (S.C., 1944).

\textsuperscript{100} See \textit{Picard, op. cit.}, footnote 14, pp. 20-21; \textit{Sharpe, op. cit.}, footnote 29, p. 186.


\textsuperscript{102} See Table B, \textit{infra}, p. 256-257.

\textsuperscript{103} \textit{R. in Right of Canada v. Saskatchewan Wheat Pool}, supra, footnote 21.

\textsuperscript{104} See the text accompanying footnote 40, \textit{supra}.
In short, what little relevant case authority there is provides no clear guidance whether a physician owes a duty to warn a partner who may be at risk of HIV infection by his or her patient. The only certain conclusion possible is that no absolutes can be derived from existing precedent. Therefore, the dilemma posed by the conflict between the clearly recognized duty of confidence and the uncertain duty to warn must, in the absence of legislation authorizing or requiring disclosure, be decided solely on policy considerations.  

III. Balancing Competing Interests  

Two policy objectives must be balanced in determining whether a duty to warn with respect to AIDS-related patient information should be recognized as an exception to the physician's duty of confidence to his or her patient. These are maintaining the patient's confidence and reducing the risk that HIV will be transmitted to the partner.  

105 See the text accompanying footnotes 33-45, supra.  

106 Policy considerations are now clearly recognized as the touchstone in the determination of questions of duty: see Anns v. Merton London Borough Council, [1978] A.C. 728, at pp. 751-752, [1977] 2 All E.R. 492, at p. 498 (H.L.), per Lord Wilberforce, as adopted by the Supreme Court of Canada in City of Kamloops v. Nielsen, [1984] 2 S.C.R. 2, (1984), 10 D.L.R. 641, and B.D.C. Ltd. v. Hofstrand Farms Ltd., [1986] 1 S.C.R. 228, (1986), 26 D.L.R. (4th) 1. Similarly, in Tarasoff v. The Regents of the University of California, supra, footnote 16, at pp. 22 (Cal. Rptr.), 342 (P.), Tobriner J., for the majority, stated: "In analyzing this issue, we bear in mind that legal duties are not discoverable facts of nature, but merely conclusory expressions that, in cases of a particular type, liability should be imposed for damage done. As stated in Dillon v. Legg (1968), 67 Cal. 2d 728, 734, 69 Cal. Rptr. 72, 76, 441 P. 2d. 912, 916: 'The assertion that liability must . . . be denied because defendant bears no 'duty' to plaintiff 'begs the essential question—whether the plaintiff's interests are entitled to legal protection against the defendant's conduct . . . [Duty] is not sacrosanct in itself, but only an expression of the sum total of those considerations of policy which lead the law to say that the particular plaintiff is entitled to protection' (Prosser, Law of Torts, [3d ed., 1964], at pp. 332-333)."  

107 See South Florida Blood Service, Inc. v. Rasmussen, 467 So. 2d 798 (Fla. C.A., 1985), as an example of balancing competing claims to disclosure and confidentiality with respect to AIDS-related personal information. An analogous balancing process has been applied to resolve competing claims to governmental or employer confidence and the right of the public to be informed. Disclosure of confidential information may be justified "in the public interest" or, alternatively and perhaps more specifically, to prevent or bring to public attention an "iniquity", "misdeed" (Beloff v. Pressdram Ltd., [1973] 1 All E.R. 241, at pp. 260-261 (Ch. D.), per Ungoed-Thomas J.) or "wrongful act" (Attorney-General of Ontario v. Gowling & Henderson (1984), 47 O.R. (2d) 449, at pp. 460-462 (Ont. H.C.) per Rosenberg J.). It has been suggested, in obiter, that this defence would apply to disclosure of "matters medically dangerous to the public" (Beloff v. Pressdram Ltd., supra, at p. 260), but it was rejected in X. v. Y., supra, footnote 16, at pp. 658-661, in which the defendant newspaper submitted that it should not be restrained from publishing AIDS-related patient information. In any event, this defence is limited to disclosure of matters which, if carried out, would be "destructive of the country or its people" (Beloff v. Pressdram Ltd., supra, at p. 260). Quaere whether HIV transmission
As indicated, 108 the purpose of the physician's duty of confidence is to encourage the patient to seek diagnosis and treatment without fear that his or her condition, ailment or treatment will be disclosed. This duty and the purpose served by it may not have much practical significance if the patient requires an appendectomy, the setting of a fracture or any other medical service to which no possible social stigma attaches. However, the knowledge by the patient that his or her condition, ailment or treatment will be kept confidential becomes essential in such medical interventions as contraception, abortion, sterilization and the treatment of venereal and other communicable diseases. It is difficult to think of a condition or ailment in respect of which the potential hardship, including employment and housing discrimination, which may be caused to the patient through disclosure of his or her condition, ailment or treatment would be greater than that of being HIV seropositive. 109 Not only does the epidemiological evidence establish that a primary mode of HIV transmission is sexual activity, 110 but also the large majority of AIDS patients to date are homosexual or bisexual men. 111 The usual difficulties associated with disclosure of patient information concerning a sexu-

would constitute such a threat, as distinguished from, say, highly infectious airborne illness or contamination of the water supply. Further, the defence is limited to disclosure of information to police or other public officials, not individuals: Attorney-General v. Guardian Newspapers Ltd. (No. 2), ("the Spycatcher case"), [1988] 2 W.L.R. 805, at p. 910 (C.A.), aff'd [1988] 3 W.L.R. 776 (H.L.). Since all provinces and territories have legislation obliging physicians to report AIDS-related patient information to medical health officers (Table B, infra, pp. 256-257), such reporting is already required.

108 See the text accompanying footnotes 16-17, supra.


110 See the text accompanying footnote 89, supra.

111 Royal Society of Canada, op. cit., footnote 1, p. 4, states: "As of March 1988 the total number of AIDS patients reported in Canada since the beginning of the epidemic was 1,644. Of these, 1,611 were adults, 33 were in the pediatric age group, and 94% of all patients were men. Ontario had the highest number at 648, followed by Quebec with 491 and British Columbia with 332. Adult AIDS patients classified by risk group were as follows: homosexual/bisexual men 81.7%; persons from endemic regions such as Haiti and Central Africa 5.3%; blood transfusion recipients 2.8%; heterosexual contacts of high-risk persons 2.5%; hemophiliacs 1.7%; injection drug users 0.6%; homosexual/bisexual men who were also injection drug users 2.7%; and those with no identified risk factor 2.7."
ally transmitted disease are therefore compounded by homophobia in the case of HIV seropositivity.\textsuperscript{112}

At first consideration, maintaining the patient’s confidence and reducing the risk that HIV will be transmitted to the partner appear inexorably to conflict. The partner could undoubtedly be protected by a warning from the physician, but this would entirely defeat the patient’s interest in confidentiality. But must the interests of the patient and the partner necessarily conflict if a warning is not given? I submit they do not. The patient’s interest in confidentiality would clearly be met and encouragement of patient testing through strict adherence to the duty of confidence would indirectly contribute to protecting the partner. Patients testing HIV seropositive are at least able to warn partners whereas HIV seropositive but untested persons, perhaps untested because of a fear of a breach of confidence, cannot warn partners.\textsuperscript{113} Similarly, detection of the patient’s HIV seropositivity may result in the partner being warned by a medical health officer.\textsuperscript{114} Further, I submit that partner protection may be in the long run better achieved through education on the need for self protection and personal responsibility than through warnings. Warnings are not necessarily effective since they may be untimely, miss partners or be based on false test results.\textsuperscript{115} On the other hand, there is evidence that education programs can work.\textsuperscript{116} However, there is the possibility that

\textsuperscript{112} X. v. Y., supra, footnote 16, at 653.

\textsuperscript{113} As stated in Nanula, loc. cit., footnote 109, at p. 333: “Instead of posing an obstacle for proponents of AIDS reporting and testing laws, the individual interest in confidentiality is in fact an important weapon in the disease control effort. The public interest in controlling the spread of AIDS will be best served by protecting against unwarranted disclosures of sensitive AIDS-related information. Constitutional protection of the confidentiality of potential AIDS carriers should help to create an atmosphere conducive to voluntary participation in reporting, testing, and education programs. Full participation in these programs in turn will promote the success of efforts to isolate, treat, and cure the deadly disease. . . . Since protecting the individual’s privacy and confidentiality interests also serves the public interest in controlling the spread of AIDS, courts should view the protection of confidentiality as a primary responsibility. . . .” See also People v. Calvo, supra, footnote 16, at p. 224; Grattan v. People, supra, footnote 16, at p. 882; X. v. Y., supra, footnote 16, at pp. 651-653, 656.

\textsuperscript{114} Considered in the text accompanying footnotes 122-125, infra.

\textsuperscript{115} See Royal Society of Canada, supra, footnote 1, pp. 3, 12.

\textsuperscript{116} Royal Society of Canada, ibid., p. 19, states: “Since sexual activity is a personal and private matter not often amenable to logical constraints, there are limits to what educational campaigns can achieve. These limits should be clearly understood. Nonetheless, education remains the main hope against AIDS until an effective preventive measure (e.g. a vaccine) or treatment is found.” See also, p. 18: “There is evidence for the effectiveness of well-crafted health promotion campaigns that are carefully targeted, that use the best available theory and technology, that offer alternatives, and that go beyond the presentation of the facts to include motivation and attitudes. Major behavioural changes have been reported among homosexual men in recent years in response to the AIDS epidemic; a decline in high-risk sexual activities has been documented in San
the partner may remain at risk of infection despite education programs. For example, the partner might believe that his or her sexual relationship with the patient is monogamous and has been for years and, therefore, might reasonably feel that methods intended to reduce the risk of HIV transmission referred to in education programs are not relevant to him or her. The position of the partner in this situation is exacerbated by the likelihood that if the patient fears disclosing his or her HIV seropositivity to the partner, the patient would similarly fear suggesting to the partner that they change their conduct to reduce the risk of HIV transmission. If unwarned, the mistaken partner obviously may remain at risk of infection. Unfortunately, perhaps the most likely such scenario is that given in the opening hypothetical.

In summary, there appears to be no completely satisfactory resolution to the problem under consideration. However, the conclusion that a physician should be held neither to owe a duty nor have a power to warn a partner of a patient’s HIV seropositivity is probably the result if the duty of confidence is required by statute since, in the absence of legislation authorizing or requiring disclosure, support for a duty to warn would be entirely at common law. For the policy reasons considered, I sub-

Francisco and in Vancouver. The rates of spread of HIV infection has also diminished significantly there. Indirect evidence that sexual behaviour has changed among certain groups is found in the large reduction in rectal gonorrhea treated at the sexually transmitted diseases clinic in Sydney, Australia. Similar patterns have been documented in Alberta. See also, K.M. Sullivan and M.A. Field, AIDS and the Coercive Power of the State (1988), 23 Harv. Civ. Rights—Civ. Liberties L. Rev. 139, at p. 193. Whether education programs directed at the general population, as opposed to those targeted at specific groups, such as homosexual and bisexual men, will be as effective is not yet known.

117 Royal Society of Canada, ibid., p. 4, states: “The first patient with AIDS in Canada was diagnosed in 1978 although the cause of his illness was not recognized at the time.” However, AIDS may have been in North America since at least 1969: see “Strange Trip Back to the Future: The case of Robert R. spurs new questions about AIDS”, Time, November 9, 1987, p. 109. The Blood Transfusion Service of the Canadian Red Cross Society, in its “Health Assessment/Donor Questionnaire” given to prospective blood donors, asks as one of its AIDS screening questions: “Are you a male that has had sexual relations with another male since 1977?”

118 Even this conclusion is not certain since a judge anxious to recognize either a duty or a power to warn exception to a statute imposing a duty of confidence may be able to construe the statute as being subject to such an exception. In Tarasoff, the majority concluded, reasonably I submit, that legislation imposing confidentiality with respect to patient information concerning specified psychiatric examinations and detentions was not applicable to the fact situation before them: see Tarasoff v. Regents of University of California, supra, footnote 16, at pp. 28-29 (Cal. Rptr.), 348-349 (P), per Tobriner J. Clark J., dissenting, specifically disagreed on the construction of the legislation: ibid., at pp. 35-38 (Cal. Rptr.), 355-358 (P). In contrast, the legislation listed in Table A, infra, p. 255, specifically mandates confidentiality with respect to, inter alia, AIDS-related patient information and I submit that it would be considerably more difficult for a judge to construe this legislation as being subject to a common law duty to warn exception than it was for the majority in Tarasoff to construe the legislation there considered as being inapplicable to the facts in that case.
mit that this should also be the result even if the duty of confidence is at common law. Thus, a partner who is not warned by the physician should not have a remedy against the physician for that failure to warn. Conversely, a patient should have a remedy against his or her physician if the physician disclosed information about the patient without consent.

I stress that the partner who is infected by the HIV seropositive patient, while not having a remedy against the physician for a failure to warn, might well have remedies against others. First, the partner would very likely have a remedy against the patient for failure to advise of his or her HIV seropositivity. Second, the partner might have a remedy

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119 Others suggest that courts may, although not necessarily should, recognize an AIDS-related duty to warn exception to the physician’s duty of confidence (Dickens, loc. cit., footnote 26), or even are likely to do so (R. Belitsky and R.A. Solomon, Doctors and Patients: Responsibilities in a Confidential Relationship, in H.L. Dalton, S. Burris and Yale AIDS Law Project, AIDS and the Law: A Guide for the Public (1987), p. 201). As to what courts should do, Mackinnon, in Royal Society of Canada, op. cit., footnote 1, p. 347, at p. 377, structures the problem as follows: “Trust is . . . an essential part of the health-care relationship and trust requires a large degree of certainty. Where it seems likely that a transmission of HIV to sexual partners could be prevented by a warning, one would wish physicians to warn potentials partners; however, if disclosure will not reduce the spread of infection and will discourage frightened persons from seeking medical care, confidentiality should not be breached.” Report of the Presidential Commission, op. cit., footnote 1, p. 129, recommends (Recommendation 9-40), that federal HIV confidentiality legislation be enacted which would provide, inter alia, that “[n]otification of sexual partners [of an HIV seropositive patient] by health care providers should be discretionary and should not be imposed as a legal duty to warn”. The Commission stated, at p. 128, that “[n]otifying sexual partners, as a legal responsibility, is the responsibility of the state or local health department”. If possible, notification should be made without disclosing the patient’s identity. With respect to such notification, see the Report, pp. 75-77. See also footnote 130, infra, concerning recent Royal Society of Canada recommendations.

120 I have focused on the civil liability of the physician. However, there is also the possibility that a physician who, without the patient’s consent, discloses patient information which by statute must be kept confidential commits a quasi-criminal offence. See, for example, in British Columbia, The Health Act Communicable Disease Regulation, B.C. Reg. 4/83, s. 6.1, as amended by B.C. Reg. 8/86, and The Health Act, R.S.B.C. 1979, c. 161, ss. 112, 115.

121 This would require, of course, that the plaintiff partner be able to establish the elements of a cause of action, such as battery, intentional infliction of emotional distress, fraud or negligence. Consent to sexual intercourse as a defence to battery is particularly problematic. See Kathleen K. v. Robert B., 198 Cal. Rptr. 273, at p. 275 and note 3 (Cal. C.A., 1984), where it was stated that a person suffering from genital herpes or AIDS who failed to disclose this information to a prospective sexual partner might be liable in tort to that partner if the partner contracted the disease, and, similarly, B.N. v. K.K., 538 A. 2d 1175 (Md. C.A., 1988), both of these cases involving the transmission of genital herpes. See also Stewart, Soltan and Thorne, loc. cit., footnote 16, at pp. 51-53, in which the authors, citing supporting textbook opinion, state that Hegarty v. Shine (1878), 14 Cox. C.C. 145 (Ir. C.A.) is probably no longer good law; and Ducharme, loc. cit., footnote 61, at pp. 494-495. A California jury recently awarded
against a medical health officer who failed to contact the partner. Provincial legislation varies, but all provinces and territories require physicians to report specified AIDS-related patient information to a medical health officer. The potential liability of a physician to the partner for a failure to report required information to a medical health officer has been mentioned earlier. In such situations, the medical health officer

Rock Hudson's former lover 14.5 million dollars against Hudson's estate because Hudson had not disclosed that he had AIDS. Significantly, the plaintiff remains HIV seronegative. See Globe and Mail (Toronto), February 16, 1989, p. A1.

122 The legislation set out in Table C, infra, p. 258, typically provides that a quasi-criminal penalty may be imposed on anyone who contravenes its provisions. This would encompass breaches by medical health officers and, in particular, failures to trace contacts of infected patients. However, such legislation provides no remedy for a contact who is infected because of the failure by a medical health officer to warn him or her. Thus, in order for the plaintiff partner to recover against a medical health officer in respect of a failure to warn, the partner would have to establish the elements of a recognized common law cause of action, such as negligence. In this context, the officer's statutory breach may be evidence of negligence: R. in Right of Canada v. Saskatchewan Wheat Pool, supra, footnote 21. However, in addition to the usual hurdles confronting a plaintiff arguing that the defendant's breach of a criminal or quasi-criminal statutory provision also constituted a breach of a common law duty of care, the plaintiff suing a public official has additional hurdles which must be met. First, legislation may bar recovery in the particular circumstances; see, for example, The Health Protection and Promotion Act, 1983, S.O. 1983, c. 10, s. 94(1). Second, even in the absence of such legislation, the plaintiff must establish that the defendant public official's act or omission was within the realm of operational as distinguished from policy decisions: Anns v. Merton London Borough Council, supra, footnote 106; City of Kamloops v. Nielsen, supra, footnote 106. For a helpful critique of the operational versus policy decision dichotomy, see D. Cohen, The Public and Private Law Dimensions of the UFFI Problem: Part II (1984), 8 Can. Bus. Law J. 410. Finally, it should be noted that the use of apparently mandatory or permissive language in the legislation creating the medical health officer's obligation to trace contacts does not work any magic in determining whether the officer's statutory breach also constituted a breach of common law duty to warn the patient's contact. (Some of the provisions listed in Table C, infra, p. 258, are apparently mandatory, others apparently permissive and others neither). As Lord Wilberforce, delivering the lead speech for an unanimous House in Anns v. Merton London Borough Council, supra, footnote 106, at pp. 755-756 (A.C.), 501-502 (All E.R.), stated: "It is said that there is an absolute distinction in the law between statutory duty and statutory power—the former giving rise to possible liability, the latter not, or at least not doing so unless the exercise of the power involves some positive act creating some fresh or additional damage. My Lords, I do not believe that any such absolute rule exists: or perhaps, more accurately, that such rules as exist in relation to powers and duties existing under particular statutes, provide sufficient definition of the rights of individuals affected by their exercise, or indeed their non-exercise, unless they take account of the possibility that, parallel with public law duties there may coexist those duties which persons—private or public—are under at common law to avoid causing damage to others in sufficient proximity to them."

123 See Table B, infra, pp. 256-257.

124 See the text accompanying footnotes 98-104, supra.
will follow up with contact tracing. Whether the identity of the patient will be disclosed as a result of contact tracing and a warning by a medical health officer will obviously depend on the circumstances. In particular, the number of sexual partners or intravenous drug sharers of the person contacted will be relevant. A partner will remain unwarned by a medical health officer if the fact situation is one not requiring the physician to report to a medical health officer or, if such reporting is required and made, the patient does not disclose the partner contact to the medical health officer. If there is no reporting obligation applicable to the particular fact situation, the partner’s claim to be warned by the physician may be more compelling than if there is such a reporting obligation, since arguably a direct warning by the physician may then be the only way in which the partner will be warned.

Conclusion

Returning to the opening hypothetical, the physician may ethically disclose the patient’s HIV seropositivity to his wife, if the criteria set by the Canadian Medical Association for such disclosure exist including, in particular, that the disclosure is made with the patient’s knowledge. However, in “answer” to the question, “What is the position of the physician legally?”, one is left with a series of further questions.

Question 1: Is there legislation requiring or authorizing the physician to make disclosure to the patient’s wife? In the Yukon Territory, if the patient has developed AIDS and, perhaps, depending upon how the territorial legislation is interpreted, if he has ARC or is HIV seropositive, the physician is required to make disclosure to the patient’s wife, and in the Northwest Territories, whether the patient has AIDS, ARC or is HIV seropositive, the physician is required either to make such disclosure or request the Chief Medical Health Officer to do so. In Prince Edward Island, whether the patient has AIDS, has ARC or is HIV seropositive, the physician is authorized, but not required, to disclose this information to the patient’s wife, since she is obviously a member of the patient’s family. In Alberta and Manitoba, it is at least possible that the physician may be authorized to make disclosure to the patient’s wife with ministerial approval. In the remaining provinces, there is no legislation requiring or authorizing disclosure and all of the following questions must be considered.

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125 Table C, infra, p. 258. For background information about contact tracing, at least in Ontario, see Krever, op. cit., footnote 25, Vol. III, pp. 79-80.
126 See the text accompanying footnote 9, supra.
127 See the text accompanying footnotes 33-40, supra.
128 See the text accompanying footnote 41, supra.
129 See the text accompanying footnote 42, supra.
Question 2: Is the wife also a patient of the physician? If the answer is “yes”, the patient’s claim to confidentiality is not as strong.130

Question 3: Is the fact situation one which gives rise to a statutory obligation on the physician to report to a medical health officer?131 If the answer is “no”, the patient’s claim to confidentiality may not be as strong.132

Question 4: If the fact situation is one which does give rise to a statutory obligation on the physician to report to a medical health officer, has the physician failed to satisfy that obligation?133 If the answer is “yes”, the patient’s claim to confidentiality may not be as strong.134

Question 5: Is the physician’s duty of confidence required by statute or is it at common law?135 If the physician’s duty of confidence is required by statute, the patient’s claim to confidentiality may be stronger

130 See the text accompanying footnotes 72-81, supra. Royal Society of Canada, op. cit., footnote 1, p. 11, states: “There are anecdotal reports of HIV-infected persons who know they are infected yet continue to have unprotected sexual intercourse with one or many unknowing partners. A strong ethical case can be made in support of a physician’s breaking confidence with a seropositive person when such a person persistently refuses to stop endangering the health and life of a sexual partner, when the physician knows the person in danger, and when the physician is the only one with that knowledge. The case is even stronger if the endangered person is the physician’s patient as well.” (Emphasis added). I caution that the Society uses the words “strong ethical case”, and not “strong legal case”, even though this comment appears in a section entitled “HIV Infection and the Law”. The Society recommends, op. cit., footnote 1, p. 11: “that provincial professional regulatory legislation provide that, where a health-care provider has reasonable cause to believe that an HIV-infected person is in such mental, physical or emotional condition as to be dangerous to others, and that disclosure of information about the patient is necessary to prevent the threatened danger, the health-care provider may disclose such information to the person or persons in danger without the consent of the patient. Disclosure made under that reasonable belief shall not amount to professional misconduct.” (Emphasis added). Notably, this recommendation is limited to questions about “professional misconduct” and does not explicitly deal with the potential legal liability of a physician to a patient about whom the physician has disclosed AIDS-related information. (In fairness to the Society, the recommendation reproduced follows immediately after another recommendation which does deal explicitly with such legal liability, giving rise perhaps to the inference that the recommendation reproduced is intended as an exception to the preceding recommendation and, therefore, intended to deal also with legal liability.) Second, this recommendation is limited to situations in which the HIV-infected patient’s “mental, physical or emotional condition” are such that the physician would have reasonable cause to consider the patient dangerous to others. This would not seem to cover a situation in which the HIV-infected patient is mentally, physically or emotionally healthy and yet still a risk to his or her partner.

131 See Table B, infra, pp. 256-257.

132 See the text accompanying footnotes 98-104, supra.

133 See Table B, infra, pp. 256-257.

134 See the text accompanying footnotes 98-104, supra.

135 See Table A, infra, p. 255.
since the duty to warn, in the absence of legislation referred to under Question 1, would be entirely at common law.\textsuperscript{136}

I have submitted that unless disclosure is authorized or required by statute, policy considerations require that the physician maintain the patient's confidence. Alternatively expressed, the physician should not be held to owe a duty to warn the patient's wife. However, the physician should not live in terror of making the wrong decision. I submit that whether or not the physician warns the patient's wife, judges will likely sympathize with a physician who must attempt to reconcile the duty of confidence to the patient and a concern for containing the spread of AIDS. Whichever way the physician decides to resolve this dilemma, judges may prefer not to attach liability to that decision.\textsuperscript{137}

\textsuperscript{136} See the text accompanying footnote 118, supra.

\textsuperscript{137} Re Attorney-General of British Columbia and Astaforoff (1983), 6 C.C.C. (3d) 498, 35 C.R. (3d) 69 (B.C.S.C.), affirmed (1983), 6 C.C.C. (3d) 503, 38 C.R. (3d) 294 (B.C.C.A.) and Attorney-General of Canada v. Notre Dame Hospital: Niemic (third party), [1984] C.S. 426. (1984), 8 C.R.R. 382, are examples of cases in which courts displayed an understandable desire to allow dilemmas to be resolved by the parties' conscience and professional ethics rather than by court orders. In Astaforoff, the court in effect declined to decide whether prison officials were under a duty to force feed a prisoner who was on a hunger strike. In Niemic, the court authorized a physician to treat a man, who was the subject of an order of deportation and who had swallowed a steel wire coat hanger, without his consent. However, the court declined to order the doctor to treat the man, which had been the order sought by the Attorney-General.
### TABLE A
Statutes and regulations requiring patient information about communicable/reportable/infectious/contagious diseases to be kept confidential.

<table>
<thead>
<tr>
<th>Province or Territory</th>
<th>Statute(s)/regulation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta</td>
<td>The Public Health Act, S.A. 1984, c. P-27.1, ss. 63(1), 63(3); but, see s. 63(5).</td>
</tr>
<tr>
<td>British Columbia</td>
<td>The Health Act Communicable Disease Regulation, B.C. Reg. 4/83, ss. 6.1, 12(6), as amended by B.C. Reg. 8/86.</td>
</tr>
<tr>
<td>Manitoba</td>
<td>The Public Health Diseases and Dead Bodies Regulation, R.R.M. 1971, Reg. P210-R2, s. 48, as amended by Man. Reg. 139/87; but, see s. 48(b).</td>
</tr>
<tr>
<td>Newfoundland</td>
<td>None.</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>The Public Health Act, S.P.E.I. 1980, c. 42, s. 22(1); but, see s. 22(2) and Notifiable and Communicable Diseases Regulations, R.R.P.E.I. 1987, Reg. EC 330/85, s. 14.</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>None.</td>
</tr>
</tbody>
</table>

**NOTES TO TABLE A:**
1. Table prepared January 1, 1989.
2. Such information is privileged in court proceedings. If such information is privileged, then arguably it must be maintained in confidence by the physician: recall footnote 11, supra p. 228, concerning the distinction between privilege and confidentiality. (3) Section 20 is limited to patient information concerning venereal disease. However, section 5 refers to “communicable disease”. (4) Sections 97 and 98 apply to venereal disease. Section 127 applies to research information; with respect to this information, see also note 2. (5) The marginal note, "privileged information", is potentially misleading. The section relates to confidentiality and, perhaps, privilege in court proceedings; recall note 11, supra, p. 228, concerning the distinction between privilege and confidentiality.
TABLE B
Statutes and regulations requiring physician reporting of AIDS-related patient information to a medical health officer.

<table>
<thead>
<tr>
<th>Province or Territory</th>
<th>Required to Report</th>
<th>Statute(s)/ regulation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Province or Territory</strong></td>
<td><strong>AIDS</strong></td>
<td><strong>ARC</strong></td>
</tr>
<tr>
<td>Alberta</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>British Columbia</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Manitoba</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Newfoundland</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Ontario</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>
NOTES TO TABLE B

1. Table prepared January 1, 1989.

2. In Rideout et al.: Keeping Confidential, Policy Options Politiques, July 1986, p. 41 at p. 42, the authors state: "In Ontario, AIDS is one of 63 diseases that doctors and other health care professionals must report to the local medical officer of health. The province is interpreting the law to mean that the names of people with the antibody to the virus must also be reported. Thus, as the law is interpreted, public health officials are entitled to the names of donors who have positive reactions to the Western Blot test. Clearly what is required is a national policy that sets out a common standard for the information to be disclosed to provincial health officials." Thus, while I have indicated that neither HIV seropositivity nor ARC is reportable under Ontario Law, it would appear that in practice medical health officers, and presumably physicians, consider that both HIV seropositivity and ARC are reportable in addition to AIDS per se. This leaves open the question whether similar legislation in other provinces, that is legislation which refers only to AIDS and not to HIV seropositivity and ARC, is in practice interpreted in a similar way so that HIV seropositivity and ARC is reportable in addition to AIDS per se. Whether such an interpretation is possible in a particular province would depend upon the entire legislative scheme relevant to AIDS, ARC and HIV seropositivity. Such a comprehensive review is beyond the scope of this article. However, by way of example, I submit that the "Ontario interpretation" referred to could not be put onto the relevant British Columbia legislation. Under the (British Columbia) Communicable Disease Regulation, B.C. Reg. 4/83, Schedule A, as amended by B.C. Reg. 31/85, "Acquired Immune Deficiency Syndrome" is a reportable communicable disease. Neither ARC nor HIV seropositivity is a reportable communicable disease. On the other hand, section 7(1) of The British Columbia Health Act, R.S.B.C. 1979, c. 161, as amended by S.B.C. 1987, c. 55, s. 8, refers to "a person [who] has a reportable communicable disease or is infected with an agent that is capable of causing a reportable communicable disease" (emphasis is mine). The distinction made between a reportable communicable disease, which would include AIDS, and being infected with an agent capable of causing a reportable communicable disease, which would include the HIV virus, leads to the inference, I submit, that the "Ontario interpretation" cannot be put on the reference to "Acquired Immune Deficiency Syndrome" as listed in Schedule A to the Communicable Disease Regulation.

3. Section 34 of the Regulation specifies the required basis for a diagnosis of AIDS. One requirement is HIV seropositivity. However, HIV seropositivity alone is not reportable.

4. Schedule A to the Regulations includes "HIV infection or A.I.D.S." as reportable communicable diseases. Since HIV infection is a prerequisite to a diagnosis of ARC, I have indicated ARC as reportable in addition to AIDS and HIV seropositivity.

5. N.S. Reg. 171/85 makes the following a notifiable disease: "Acquired immune deficiency syndrome (known as AIDS), including (a) a diagnosis of AIDS, or (b) one positive result on an ELISA test." (emphasis is mine) Since the ELISA test is the most commonly used screening test to determine HIV seropositivity, I have indicated ARC and HIV seropositivity as reportable in addition to AIDS per se. Interestingly, although AIDS was made a "notifiable disease", it was not added to the list of "communicable diseases" in section 1(c) of Act. (Some sections of the Act refer only to communicable diseases.) Arguably, however, AIDS is also a communicable disease since section 1(b) of the Regulation defines a "communicable disease" as "any disease, which by reason of its being caused by a certain specific infective agent is capable of being transmitted from one person to another, by the transmission either directly or indirectly, of the causative specific infective agent".

6. Section 17 of the Regulation provides, in part, that "any occurrence of the following diseases must be reported: ... Acquired Immune Deficiency Syndrome (AIDS), HIV antibodies, ...". Without commenting on the listing of "HIV antibodies" as a "disease", I note that because of the reference to "HIV antibodies", I have included HIV seropositivity and ARC as reportable in addition to AIDS per se.

7. Section 1(o) of the Regulation includes the following as reportable communicable diseases: "Acquired Immune Deficiency Syndrome (AIDS), and Human Immuno-deficiency Virus (H.I.V.) infection". Therefore, I have included ARC and HIV seropositivity as reportable in addition to AIDS per se.
<table>
<thead>
<tr>
<th>Province or Territory</th>
<th>Statute(s)/regulation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>None. See note 2.</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>No specific provision, but see General Regulation—Health Act, N.B. Reg. 84-283, s. 98. See note 2.</td>
</tr>
<tr>
<td>Newfoundland</td>
<td>None. See note 2.</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>None. See note 2.</td>
</tr>
<tr>
<td>Ontario</td>
<td>None. See note 2.</td>
</tr>
<tr>
<td>Quebec</td>
<td>No specific provision, but see Public Health Protection Act Regulation, R.R.Q. 1981, c. P-35, r. 1, s. 38, as amended by O.C. 975-83, s. 9. See note 2.</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>Control and Notification of Communicable Disease Regulation, Sask. Reg. 307/69, s. 8, as amended by Sask. Reg. 168/76, s. 10.</td>
</tr>
</tbody>
</table>

NOTES TO TABLE C: (1) Table prepared January 1, 1989. (2) Ontario has no legislation specifically authorizing contact tracing. However, there is no doubt contact tracing is done in Ontario: see note 125 to text. This is relevant to other provinces which similarly have no legislation specifically authorizing contact tracing.