



Royal College of
Dental Surgeons of Ontario

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The Legal and Human Rights Ramifications of Serology Testing for Dental Professionals

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Introduction to the problem

This preliminary analysis of a difficult and multi-faceted set of health care issues was first prepared for a presentation to the Canadian Dental Regulatory Authorities Federation on October 24, 2008 in Montreal. In sequence, we pose the issue of serology testing of applicants, students, members and membership candidates in dental schools and dental regulatory bodies; describe the incidence and rationale of such testing; provide an introduction to applicable human rights principles; and offer some tentative observations on the legality of such testing. Any individual case or policy, of course, deserves an individualized factual and legal assessment.

Professional regulators and serology testing

Most dental schools and some hospitals in Canada are considering the implementation of serology testing and expressing concerns about the potentially serious consequences of failing to take action. The majority of dental regulators currently have a process in place for members who are Hepatitis B positive. The process of the Royal College of Dental Surgeons of Ontario (RCDSO) involves the creation of an expert panel that normally consists of a virologist, haematologist, and infection control expert. These individuals meet anonymously with the member or applicant whose serologic status is at issue to make recommendations regarding necessary restrictions for safety purposes. The applicant or member is permitted to have a representative on the panel. Ultimately, the member or applicant will be asked to accept the recommendations of the panel. If he or she does not do so, the Registrar can invoke the Fitness to Practise provisions of the Regulated Health Professions Act.¹

The College of Physicians & Surgeons of Ontario (CPSO) policy on blood-borne pathogens indicates that “all practising physicians in Ontario should conscientiously and rigorously adhere to the principles of universal precautions in their practice.”² The policy also states that all practising physicians should be immunized against Hepatitis B for the protection of themselves and their patients. While a small number of individuals may not respond to the vaccine, such individuals are encouraged

to seek additional or higher doses of vaccine or a different vaccine to make every effort to obtain seroconversion.³

Furthermore, the policy states that all physicians who perform exposure-prone procedures are ethically obligated to know their serologic status as regards HBV, HIV and HCV.⁴ Periodic testing is recommended. A physician who performs exposure-prone procedures and learns that he or she is positive for HIV, HBV or HCV is ethically obligated to contact the College for a review of whether this status will have an effect on his or her medical practice. The College will make practice modifications where appropriate on the advice of experts in the field.⁵ In practice, few physicians report a positive HIV, HBV or HCV status to the CPSO.

Canadian dental schools and serology testing

In 2000, a peer-reviewed medical journal article discussed the risk of transmission of Hepatitis B virus from dentists to patients and completed a survey of Canadian dental schools regarding serology testing policies.⁶ The article notes that chronic carriers of Hepatitis B with e antigen (HBeAg) pose significantly higher infectivity than carriers for Hepatitis B without the e antigen. It cites Health Canada’s policy recommending mandatory Hepatitis B vaccination of dentists and health care workers who perform “exposure-prone procedures” as well as subsequent mandatory serology tests to confirm immunity.⁷ Although there had been no reported Hepatitis B transmission from dental student to a patient at the time the article was published, the author considered such transmission to be a risk posed particularly since dental students may still be developing their clinical skills and may be prone to making mistakes.⁸ Standard precautions do not completely prevent exposure and transmission of Hepatitis B. From 1972 to 1999, 46 health care workers, nine of whom were dentists, transmitted Hepatitis B to their patients.⁹ Needle-stick injuries were also relatively common.

The article surveyed ten Canadian dental schools and found that eight of them required successful applicants to provide documented evidence of Hepatitis B vaccination. The other two schools encouraged but did not formally require Hepatitis B vaccination. Three of the

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schools required applicants to undergo serological testing after Hepatitis B vaccination to confirm immunity.¹⁰ University of Alberta's legal position for screening applicants and excluding HBeAg carrier was as follows:

A university may successfully defend against a claim of discrimination, on the basis that the denial of service or facilities is reasonable and justifiable in the circumstances. For example, excluding students with certain infectious diseases from participating in a clinical placement would be discriminatory but may nevertheless be reasonable and justifiable in the circumstances having regard to the competing interest of patient safety. In order to successfully rely on health or safety considerations to justify a discriminatory rule or practice, it must be shown on the basis of authoritative and up-to-date medical scientific or statistical information, that there is a sufficient risk to others.¹¹

A 2003 review of Canadian dental schools indicated a variation in policies across schools, with some prohibiting the clinical activities of infected dental students, and others recommending vaccination and nothing more.¹² A current online search of the websites for Canadian dentistry programs indicates that a number of schools require applicants to be tested for Hepatitis B. At the Schulich School of Medicine and Dentistry at the University of Western Ontario, applicants are required to be tested for Hepatitis B surface antigen. Those who test positive for Hepatitis B e antigen and/or if the Hepatitis B viral DNA is positive, an offer of acceptance will be withdrawn and registration to the program will not be completed. The University's page on admission states the requirement as follows:

"Current information indicates that there is a potential risk of transmission of Hepatitis B from practitioner to patients in the clinical dental setting. Therefore, applicants will be required to be tested for Hepatitis B surface antigen by Student Health Services at The University of Western Ontario. Applicants who test positive for Hepatitis B surface antigen will be tested for Hepatitis B "e" antigen and Hepatitis B viral DNA

to help determine infectivity risk. If Hepatitis B "e" antigen and/or Hepatitis B viral DNA is positive, the offer of acceptance will be withdrawn and registration to the DDS program will not be completed. Should a student's HBV serostatus change, his/her eligibility for admission could be reassessed."¹³

At the University of British Columbia (UBC), potential applicants are advised that Hepatitis B antigen positive status may limit their ability to complete the dentistry program or to practise dentistry after graduation. The statement provided by UBC specifically states that accommodation through the elimination of procedures with a high risk of exposure are not possible within the field of dentistry:

"Students who are Hepatitis B antigen positive may pose a risk of passing infection to others. While the UBC Faculty of Dentistry does not currently take Hepatitis status into account when admitting students, potential applicants should know that Hepatitis B antigen positive status may limit their ability to complete our DMD program or to practise dentistry after graduation. *While medical schools may offer a modified course of training (e.g. no invasive procedures) during the MD program and suggest "non-operative" career choices, dentistry is a surgical specialty involving the regular and ongoing performance of invasive, and therefore potentially infective, operative procedures as part of its education and practice. These procedures are an integral and required part of the DMD educational program and therefore cannot be modified to accommodate Hepatitis B antigen positive students.* While the Faculty currently recommends and teaches standard precautions for all clinical procedures regardless of the health status of the operator or the patient, potential applicants who are Hepatitis B antigen positive should nevertheless consider another career choice that offers alternatives to performing invasive procedures. All students are strongly encouraged to know their serological status for Hepatitis B prior to applying to the DMD program at UBC."¹⁴ (Emphasis added)

The University of Toronto requires accepted applicants to provide documentary proof of current immunization against Hepatitis B. McGill University requires proof of Hepatitis B vaccination and positive anti-Hepatitis B surface antigen serology. Students who do not meet these requirements will be forced to withdraw. McGill's website indicates:

Proof of immunity must be written and signed by either a nurse or a physician and include the following:

[...]

Proof of Hepatitis B vaccination and positive anti-Hepatitis B surface antigen serology (i.e. anti-HBs). "Immunity" to Hepatitis B may be documented by both a positive anti-Hepatitis B core antigen serology (i.e. anti-HBc) and absence of Hepatitis B surface antigen (i.e. HBsAg). In this latter case, vaccination is not necessary.

[...]

There are no exceptions to these requirements. Students who do not meet these requirements will be asked to withdraw.

Background: Hepatitis B

As of 2003, there were an estimated 350 million chronic carriers of Hepatitis B worldwide, with a prevalence of 10-18 per cent in surgeons.¹⁵ HBV can be transmitted by "percutaneous exposure, permucosal exposure, sexual contact, or perinatally".¹⁶ The estimated risk of transmission from a health care worker infected with HBV to a patient is 240-1400 transmissions per 1,000,000 procedures.¹⁷ The seroconversion rate for an unprotected individual after significant exposure to an HBeAg positive health care worker is 19-30 per cent.¹⁸ For an HBeAg negative health care worker, the risk is estimated to be 5 per cent.¹⁹

Prevention and treatment of HBV and compliance with standard precautions

Recombinant vaccine can provide a 95-99 per cent protective immune response against an HBV infection.²⁰ In addition to vaccinations for dental students, surgical patients can be offered immunization prior to elective invasive procedures.²¹ Standard precautions and the use

of double gloves can also limit transmission, yet studies indicate that compliance with standard precautions may be lower than one would expect. One study published in the mid-1990s revealed a compliance rate of 31.3 per cent with standard precautions across emergency departments, dental clinics, and plastic surgery clinics.²² The explanation for such a low adherence rate to standard precautions is unknown. Active efforts to maintain compliance with standard precautions are essential to help prevent transmission.²³

The provision of antiviral therapy to an infected health care worker may enable a health care worker to perform his or her job while limiting the risk of transmission to patients. Some studies indicate that suppressing the viral load in HBV-infected health care workers can minimize the risk of doctor to patient transmission such that further job modifications may not be required.²⁴ Such measures may satisfy the legal duty to accommodate, which we discussed below.

Guidelines for health care workers

In the United States, the Center for Disease Control suggests in its guidelines for infection control in dental settings that an HBeAg positive HBV carrier should be restricted from performing exposure-prone invasive procedures until a review has been conducted by an expert panel.²⁵ This restriction would remain in place until the individual is HBeAg negative. The Society for Healthcare Epidemiology of America recommends that HBeAg positive health care workers should not perform exposure-prone procedures.²⁶

In 1996 Health Canada recommended in its guidelines that any health care worker or student who is infected with a blood-borne pathogen and who performs or will perform exposure-prone procedures be referred to an expert panel.²⁷

Information on risks of transmission may be very important to patients, particularly if they could easily have the procedure performed by another individual. However, the long term effects of an illness such as Hepatitis B may be less of a concern for a terminally ill patient. As a frame of reference, patients frequently consent to the risk of death from anaesthesia, which is 10 per 1,000,000.²⁸

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Perception of risk

In examining the issue of risk to the public from an infected health care professional, one must balance the rights of the health care worker, professional organizations, and others. A brief discussion of this balance is provided by the Public Health Agency of Canada:

Along with the actual risks of transmission of HBV, HCV or HIV the risk perceived by the public has to be considered in determining an acceptable risk. A lay person's perception of risk can lead him or her to believe that a) even if only one life is saved, an action is worth taking, and b) any identifiable risk of transmission is unacceptable. When zero risk is not attainable, recommendations must strike a balance between the rights and reasonable expectations of the public and the rights and responsibilities of individual HCWs, health care facilities, professional organizations, licensing bodies and governmental health departments. The public has rights that must be protected, but the public also has responsibilities. In this situation the public's responsibilities include the following:

- a) basing perceptions on reliable information and sound scientific principles, and
- b) giving due consideration to the rights of the infected HCW.²⁹

HIV

There has been a shift towards making HIV testing programs more routine in certain circumstances over the past 15 years.³⁰ One area of testing involves the routine screening of pregnant woman and/or newborns. The United States has moved towards "opt-out routine HIV screening for pregnant women and routine or mandatory screening for newborns once therapies become available to reduce the risk of perinatal transmission."³¹ In Canada, most provinces have a version of prenatal HIV screening as well.

Mandatory HIV testing may also occur for health and safety purposes of third parties. The least controversial example of this is the testing that occurs in the blood donation process.³² Another area involves post-exposure

testing for those who have been exposed to the blood or body fluids of HIV or other blood-borne pathogens. Three standard examples of circumstances involving post-exposure testing involve individuals who have been exposed through accidents, such as individuals who have been exposed in emergency medical situations; those who have been exposed through the performance of their duties, such as police officers and emergency responders; and those exposed through criminal activity, such as victims of sexual assault.³³

Post-exposure testing

Legislation in Ontario, Alberta, Nova Scotia, and Saskatchewan permits mandatory testing under some circumstances. In Ontario, victims of crimes and good samaritans can apply to have the "source" party tested for HIV, Hepatitis B, and Hepatitis C.³⁴ In Alberta, certain emergency first aid caregivers, firefighters and police officers who have been exposed to the blood or body fluid of another may apply for compulsory testing of the relevant individual.³⁵ Similarly, in Nova Scotia, one can apply for a testing order if exposed as a victim of a crime, as one who provided emergency health care services or duties as a firefighter, peace officer, police officer, or prison guard, or as someone who performed some other function in relation to the source person that is not set out in the regulations.³⁶ Although legislation provides for post-exposure testing in several provinces, it is not without its critics. Some argue that such testing may violate the section 7 and section 8 Charter rights of security of the person and freedom from unreasonable search and seizure.³⁷

Testing of visitors and immigration applicants

HIV testing has also been imposed on visitors and potential immigrants in various countries, although such testing has been rejected by international guidelines.³⁸ The medical examinations required of visitors and immigration applicants to Canada may include screening for HIV infection. The immigration testing rules are justified as necessary to implement the provisions of the Immigration and Refugee Protection Act which target those who are "reasonably...expected to cause excessive demand on health or social services."³⁹

HIV infected physicians

While physicians owe their patients a fiduciary duty, it is not clear whether or not HIV infected physicians must disclose their status to their patients.⁴⁰ There has been little litigation in this area under Canadian law. There have, however, been cases in which dentists have been found to have discriminated against patients with HIV by refusing to treat them on the basis of HIV infection.⁴¹ After facing public scrutiny regarding an HIV-infected physician, the Quebec College of Physicians (the College) released a statement regarding its policy on the subject.⁴² In exploring the issue of infected health care workers, the policy provides information that is useful to the analysis at hand. The College adopted the definition of an exposure-prone procedure proposed at the Canadian Consensus Conference on Infected Health Care Workers in 1998:

- a) digital palpation of a needle tip in a body cavity (a hollow space within the body or one of its organs) or the simultaneous presence of the health care worker's finger and a needle or other sharp instrument or object in a blind or highly confined anatomic site, e.g. during major abdominal, cardiothoracic, vaginal and/or other orthopedic operations, or
- b) repair of major traumatic injuries, or
- c) major cutting or removal of any oral or perioral tissue, including dental structures [...].⁴³

Regarding the fitness to practise of those physicians who test positive for blood-borne pathogens, the College indicated that an infected physician will be unfit to practise unless he or she submits to a professional practice evaluation by a committee of experts:

“An infected physician who performs exposure-prone procedures is presumed to be unfit to practise his or her profession if he or she has not submitted his or her professional practice to an evaluation by a committee of experts or if he or she does not respect the practice restrictions to be observed.”⁴⁴

The College advocated against a “zero-risk” policy, stating that such a standard could lead to inappropriate screening, stigmatization, and a lack of respect for one’s human rights. The College also stated that coercive measures can lead to secretiveness and therefore increase the risk of exposure to patients rather than limit it.⁴⁵ Foreshadowing the human rights principles which we discuss below, the policy of the College did not support systematic screening of its members, finding such a process to be “medically unnecessary and potentially harmful” for the following reasons:

- one cannot screen for all blood-borne pathogens;
- blood tests have their limitations;
- the results provide information on past exposures only;
- one cannot guarantee against future infections;
- one cannot establish a periodicity for blood testing;
- one cannot guarantee an absence of risk even with screening.⁴⁶

Furthermore, the College outlined five broad guidelines for the practice of its physicians:

1) Physicians must apply standard precautions for the prevention of infections.

The College stated that the application of standard precautions is the best means of protecting both patient and physician against any pathogen. The College also advised that every medical student, medical resident, and physician act at all times as if every patient had a blood-borne infection.⁴⁷

Standard precautions were said to include:

- immunization against Hepatitis B and later verification of immunity;
- personal protection measures applicable during surgical procedures, according to standards in effect.

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For example, this includes:

- the use of protective clothing;
- the wearing of two pairs of gloves;
- the use of needle holders;
- the use of the no-touch technique, which consists of using a tray as intermediary to hand over instruments;
- the use of electric bistouries or any other devices that prevent bleeding;
- the use of blunt needles or suturing techniques without needles.⁴⁸

The remainder of the College's guidelines were as follows:

- 2) Physicians exposed in a personal or professional context to blood-borne pathogens must know their status regarding these infectious agents.
- 3) Physicians must consult an attending physician if they are infected.
- 4) Infected physicians must have their professional practice assessed initially and periodically by a committee of experts, if they perform exposure-prone procedures. They must then comply with the recommendations made by this committee.
- 5) Physicians must know and respect the Code of Ethics of Physicians.⁴⁹

Disability in services, employment and vocational associations

Section 1 of the Ontario Human Rights Code⁵⁰ guarantees the right of every person to be treated equally with respect to services, goods and facilities. In *Trinity Western University v. College of Teachers (British Columbia)*⁵¹ and in *Peel Board of Education v. Ontario (Human Rights Commission)*,⁵² education was held to be a service under the Code. The right to equal treatment applies to dental students in publicly and privately funded educational facilities including universities and clinical settings.⁵³ As such, s. 1 of the Code provides protection in professional schools such as dental faculties. Equally, s. 1 applies to patients in health care facilities. The provision reads as follows:

Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability.⁵⁴

Section 5(1) guarantees the right of every person to be treated equally in employment setting discrimination. The section applies to employees and self-employed individuals in any dental practice or hospital.

Section 6 also prohibits discrimination on similar grounds, including disability, in relation to membership in vocational associations. These include self-regulating professional bodies such as dental regulators. The provision reads as follows:

Every person has a right to equal treatment with respect to membership in any trade union, trade or occupational association or self-governing profession without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability.⁵⁵

"Disability" as defined in s. 10(1) of the Code includes:

(a) any degree of physical disability, infirmity, malformation or disfigurement that is caused by bodily injury, birth defect or illness and, without limiting the generality of the foregoing, includes diabetes mellitus, epilepsy, a brain injury, any degree of paralysis, amputation, lack of physical co-ordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, or physical reliance on a guide dog or other animal or on a wheelchair or other remedial appliance or device...⁵⁶

Accommodation and undue hardship

Under sections 5, 6 or 7 of the Code, there is a duty to accommodate an individual with a disability up to the point of undue hardship. In a policy paper on drug and alcohol testing, the Ontario Human Rights Commission refers to *Entrop*⁵⁷ and *Meiorin*⁵⁸ in stating that while such testing is prima facie discriminatory, employers can justify discriminatory rules if they meet the following three-part test⁵⁹:

- 1) The employer has adopted the standard or test for a purpose that is rationally connected to the performance of the job;
- 2) The employer adopted the particular standard or test in an honest and good faith belief that it was necessary to the fulfillment of that legitimate work-related purpose; and
- 3) The standard or test is reasonably necessary to the accomplishment of that legitimate work-related purpose. To show that the standard is reasonably necessary, it must be demonstrated that it is impossible to accommodate individual employees sharing the characteristics of the claimant without imposing undue hardship upon the employer.

This test has been clarified by the *Hydro-Quebec*⁶⁰ case, in which the Supreme Court of Canada noted that the term “impossible” as originally used in *Meiorin* had led to difficulty with the concept of undue hardship. The court stated:

The test is not whether it was impossible for the employer to accommodate the employee’s characteristics. The employer does not have a duty to change working conditions in a fundamental way, but does have a duty, if it can do so without undue hardship, to arrange the employee’s workplace or duties to enable the employee to do his or her work.⁶¹

While this jurisprudence refers to an employment context, the duty to accommodate to the point of undue hardship is equally applicable to services and regulatory bodies.

The onus is on the university, hospital or dental college to demonstrate that it would suffer undue hardship if it undertook further efforts to accommodate the applicant’s or member’s disability; for example, by standard precautions or modification of dental services or instruction.

Undue hardship is a difficult threshold to meet. It means more than mere hardship.⁶² In Ontario it can take into account only two factors: cost and health and safety risk, including protection of the public or other dental students, professors or practitioners.⁶³ And to constitute

undue hardship, the accommodation must threaten the significant interests of the institution, such as its financial well-being or the essential character of its activity.

Serology testing for HIV and Hepatitis

In its policy statements, the Ontario Human Rights Commission recognizes AIDS and other HIV-related medical conditions as disabilities under the Ontario Human Rights Code.⁶⁴ All persons infected with HIV or HIV-related illnesses are protected against discrimination in employment services and vocational associations.⁶⁵ In *Biggs v. Hudson*,⁶⁶ the British Columbia Human Rights Council held that AIDS was a disability within the meaning of the Act.⁶⁷

The Commission’s Policy on Employment-Related Medical Information does not directly address serology tests for communicable diseases.⁶⁸ As a matter of policy, the Commission recommends that any medical assessment “to verify or determine an individual’s ability to perform the essential duties of a job” should take place only after a conditional offer of employment is made.⁶⁹ Doing so allows the applicant to be considered based on his or her merits during the selection process.⁷⁰ Employment-related medical assessments are generally discriminatory unless there are bona fide reasons as justifications.⁷¹ Section 3 of the policy on HIV/AIDS-related discrimination also addresses standard precautions and medical testing for employment.⁷² In the context of serology testing for dental students and professionals, the policy would dictate assessments should only take place after a conditional offer of acceptance or employment has been made.

Drug and alcohol testing of employees

The law on drug and alcohol testing of employees may afford a useful analogy to the serology testing of dental professionals. The recent decision in *Alberta (Human Rights and Citizenship Commission) v. Kellogg Brown & Root*⁷³ (KBR) is the first appellate case that explicitly recognizes the employer’s right to impose pre-employment drug testing in safety sensitive jobs. The court declined to follow the *Entrop*⁷⁴ decision in Ontario, and held that a testing policy that targets those who test positive for drugs does not necessarily offend human

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rights. The court found that the employer's policy did not proceed from a perception that all persons who tested positive for drugs and alcohol were addicted (and therefore disabled), but rather, that those who use drugs posed a safety risk in an inherently dangerous workplace.

The case involved a prospective employee who was offered employment on the condition that he pass a pre-employment drug test. Mr. Chiasson was allowed to start his job before the results of the test were in. When the results came back positive for marijuana usage, the employee was dismissed. Mr. Chiasson filed a human rights complaint following his dismissal, alleging that he had been discriminated against on the basis of a perceived disability.

The employee alleged that he was discriminated against on the basis of an addiction although admitting that he was not addicted to marijuana. The court held that although there is an overlap between the effects of casual drug use and drug use by an addict, that does not mean that the testing policy of the employer created a perception that a casual drug user is an addict. Rather, the policy flowed from the premise that any level of alcohol in a driver's blood reduces his ability to operate the employer's vehicles safely. In this case, there was no discrimination within the meaning of the human rights statute, so no issue of accommodation or bona fide occupational qualification arose. The court did not answer whether the company's drug testing policy discriminated against addicts generally as it found that this question was not before the court.

The Alberta Court of Appeal decision is significant as it declined to follow the Ontario ruling in *Entrop v. Imperial Oil Limited*.⁷⁵ In *Entrop*, drug and alcohol testing prior to employment, and random testing, were found to be impermissible because such tests did not measure current impairment, but only whether a drug or alcohol was present in the body.

While the recent finding in *KBR* provides support for testing in safety sensitive environments, the distinction arises that the employee in *KBR* did not have a disability, and as such, accommodation did not have to be considered. In contrast, an individual who tests positive

for Hepatitis B or C or HIV would be held to have a disability under the Code, and thus a duty to accommodate would exist to the point of undue hardship.

Drug and alcohol testing as a medical examination

Since testing for drug or alcohol use constitutes a medical examination, the OHRC policy guide (relying to a great extent on *Entrop*) indicates that the following principles should be kept in mind⁷⁶:

- i) Employment-related medical examinations or inquiries, conducted as part of the applicant screening process, are prohibited under section 23(2) of the Code.
- ii) Pre-employment medical examinations or inquiries at the interview stage should be limited to determining an individual's ability to perform the essential duties of a job.
- iii) In order to implement a testing program prior to hiring, the employer must therefore be able to demonstrate that pre-employment testing provides an effective assessment of the applicant. Since drug testing cannot be shown to actually measure impairment, pre-employment drug testing should not be conducted. Although there has been no clear indication from the courts, it is the Commission's view that, in the absence of clear medical research, pre-employment alcohol testing does not appear to predict an employee's ability to perform the essential requirements of a safety-sensitive position. All it can do is assess impairment before the person is actually on the job. It is therefore difficult to see how an employer could justify pre-employment alcohol testing.
- iv) Medical examinations to determine an individual's ability to perform the essential duties of a job should only be administered after a conditional offer of employment has been made, preferably in writing.

- v) Where drug or alcohol testing will be a valid requirement on the job, the employer should notify job applicants of the requirement at the time that an offer of employment is made. The circumstances under which such testing might be required should be made clear to the applicant.
- vi) If the applicant or employee requests accommodation in order to enable him or her to perform the essential duties of the job, the employer is required to provide individual accommodation unless it is impossible to do so without causing undue hardship.

The OHRC policy paper indicates that drug and alcohol testing should be limited to determining actual impairment of an employee's ability to perform or fulfill the essential duties or requirements of the job. It should not be directed towards simply identifying the presence of drugs or alcohol in the body. In applying this rule to the context of serology testing for dental professionals, clearly such testing would not be justified for the sake of identifying those affected by Hepatitis B alone. Rather, the actual impairment or the ability of a dental student or professional to perform the essential duties of the job as a result of his or her Hepatitis B positive status would have to be demonstrated to justify the testing. In the case of *Centre d'accueil Sainte-Domitille v. Union des employés de service, local 298*,⁷⁷ an arbitrator ruled that an employer does not have the right to require a medical examination where the purpose is merely to obtain evidence that the employee is HIV-positive, when that status poses no danger to others.

Drug and alcohol safety that has no demonstrable relationship to job safety and performance has been found to be a violation of employee rights.⁷⁸ The relationship and rational connection between such testing and job performance is an important component of a testing policy. The OHRC paper indicates that the testing policy must not be arbitrary in terms of which groups of employees are subject to testing, and notes that only testing new or returning employees but not others may not be justifiable depending upon the objectives of a company's testing policy.⁷⁹ By analogy then, it may not be justifiable for dental schools to

implement a policy of testing only new applicants to the school for Hepatitis B where existing students are not being tested.

Applying these principles to serology testing, dental schools would need to keep in mind that medical examinations as part of the screening of applicants would likely be prohibited, and that medical examinations prior to admission or at the interview stage should be limited to determining an individual's ability to perform the essential duties of the position. If students are to be tested, this should only take place after a conditional offer of acceptance is made. Furthermore, if serology testing will take place during the program, students should be notified of the requirement at the time that an offer of acceptance is made.

The central question is whether a positive Hepatitis B serostatus does in fact prevent a student from performing the essential elements of the dental school program, or conversely, whether accommodation is possible. Are there safety precautions that are sufficient to prevent the transmission of the disease? Would it be possible to opt out of any especially high risk procedures to ensure safety, or are such procedures a critical component of the schooling? According to the following posting on the University of British Columbia's website, modifications would not be possible:

While medical schools may offer a modified course of training (e.g. no invasive procedures) during the MD program and suggest "non-operative" career choices, dentistry is a surgical specialty involving the regular and ongoing performance of invasive, and therefore potentially infective, operative procedures as part of its education and practice. These procedures are an integral and required part of the DMD educational program and therefore cannot be modified to accommodate Hepatitis B antigen positive students.⁸⁰

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Individualized or personal accommodation

Section 17 of the Code is also relevant to this analysis, as it requires that individualized or personalized accommodation measures are taken to accommodate someone with a disability. As such, the OHRC policy guide indicates that policies resulting in automatic loss of employment, reassignment or inflexible reinstatement conditions without regard for personal circumstances are unlikely to meet the requirements of s.17.

Nevertheless, it is recognized in some circumstances that a person's disability may preclude performance of the essential duties of a job, in which case s.17 will not be infringed due to differential treatment.

Based on the information that we have received, it seems that personal accommodation is more feasible in medical schools versus than in dental schools as it would be possible for physicians to avoid exposure-prone procedures. Activities in the dental field may inherently involve a high degree of risk. This again leads back to a factual analysis of whether modifications are possible for dental students and dentists. Are there certain high risk procedures that a student or dentist can refrain from performing for the purposes of accommodation, or are the procedures an integral part of the dentistry program that cannot be modified, as indicated on the University of British Columbia's website? Would standard precautions, the immunization of patients, or antiviral therapy be sufficient protection against the risk of transmission?

Onus on parties to cooperate in finding accommodation

"A person who requires accommodation in order to perform the essential duties of a job has a responsibility to communicate the need for accommodation in sufficient detail and to cooperate in consultations to enable the person responsible for accommodation to respond to the request."⁸¹

This requirement suggests that dental students or dentists may be obliged to report on a positive infective status to the school or other relevant body. Those suffering from the illness would need to take further safety precautions to protect their patients, or adhere stringently to universal safety practices. Dental schools

may argue that they need to be informed regarding a student's serological status to ensure that the appropriate safety precautions are taken.

Tort liability

The trial decision in *Halkyard v. Mathew*⁸² suggested that an HIV-infected physician does not have a duty to disclose his or her status to patients.⁸³ In this case, the Alberta Court of Queen's Bench considered a claim that a surgeon with epilepsy had a duty to disclose his condition to his patient as a material risk under the informed consent process. The court rejected the claim, finding that any issues about the ability of the defendant to continue to practise should be dealt with by his medical providers and the hospital in which he practised rather than through the doctrine of informed consent. However, the Court of Appeal in affirming the judgment noted that the result might have been different if the plaintiff had been able to demonstrate harm caused by the failure to disclose.⁸⁴

Privacy law

In 2005, the Freedom of Information and Protection of Privacy Act⁸⁵ (FIPPA) was amended to include educational institutions. As of June 10, 2006, these institutions became subject to the requirements of FIPPA. An educational institution is defined in the act as "an institution that is a college of applied arts and technology or a university."⁸⁶ FIPPA governs the protection of the privacy of individuals with respect to personal information about themselves, and provides individuals with a right of access to that information held by the institutions.

The right of access is governed by the principles that information should be available to the public and exemptions from rights of access should be limited and specific. A university is not to use personal information in its possession except for the purpose for which it was obtained or for a consistent purpose, or where the individual has consented to its use.⁸⁷ "Personal information" includes the fingerprints or blood type of an individual, and would likely include such sensitive information as one's serostatus as supplied to a dental school or to an employer. Each Ontario university makes available on its website information related to how it intends to administer its responsibilities under FIPPA.⁸⁵

Conclusion

The potential risk of transmission must be weighed against the invasion of privacy to the student. While one's serological status may be a risk factor for patients or other students upon which the affected individual is operating, a zero risk policy is never possible. Patients are routinely exposed to a number of factors that may present a degree of risk that one cannot test for, such as the stress, fatigue, or personal problems that may affect the performance of a dentist or dental student. A focus on standard precautions, vaccinations, and perhaps antiviral therapy for those with a positive serostatus may well be a more effective and ethical means of warding against transmission than a policy of testing and screening out those applicants with Hepatitis B. It is important that in weighing the risks to both patients and Hepatitis B positive students or practitioners to avoid the temptation to jump to what appears to be an easy solution. We need only reflect upon the discrimination and widespread public fears regarding HIV and AIDS in the late 1980s and early 1990s to remind ourselves of the need to ensure that any steps taken are ethical and rationally connected to the relevant medical data.

The Legal and Human Rights Ramifications of Serology Testing for Dental Professionals

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