Non-Nominal HIV Antibody Testing: Guidelines for Physicians and Medical Officers of Health

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HIV AIDS

DRAFT
FOR DISCUSSION ONLY

Introduction

Ontario Regulation 490/85 under the Health Protection and Promotion Act has been amended to allow for non-nominal HIV (human immunodeficiency virus) testing and reporting. The amendment reads as follows:

(1.1) A physician who forms an opinion that a patient is or may be infected with an agent of AIDS (HIV) is exempt from reporting the name and address under section 26 of the Act to a medical officer of health for sixty days following the time the physician formed the opinion unless the physician has reason to believe that the patient will expose others to infection with an agent of AIDS (HIV).

(1.2) After the sixty days mentioned in subsection (1.1), the physician is exempt from reporting the patient's name and address to the medical officer under section 26 of the Act if the following conditions are satisfied:

1. The physician has no reason to believe that the patient will expose others to infection with an agent of AIDS (HIV).
2. For each identifiable person who may have been exposed to the risk of infection with an agent of AIDS by the patient through sexual intercourse, the sharing of needles for injections or any other way, either,
   i. the physician has notified the person of the risk of infection and of the availability of counselling about preventing the transmission of HIV infection,
   ii. the physician is satisfied that the patient has so notified the person, or
   iii. the physician or the patient has identified the person to the medical officer of health who has agreed to ensure that the person is so notified.
3. The physician is satisfied that the patient has received counselling about preventing the transmission of HIV infection.
4. The physician reports the patient's initials, sex and date of birth, including year of birth, to the medical officer of health.

(5) The operator of a laboratory is exempt from reporting, under section 29 of the Act, the name and address of a person who has tested positive for an agent of AIDS.

The purpose of these guidelines is to help physicians and medical officers of health implement Ontario Regulation 490/85, and to determine that, in the actions they have taken, the physicians, patients and medical officers of health have satisfied the criteria for non-nominal reporting. These guidelines will help ensure that the exemptions under the Act and the responsibilities of people seeking non-nominal reporting are interpreted consistently across the province.

Background

The purpose of HIV antibody testing is to encourage people who are at risk to come forward, be diagnosed early in the disease — preferably before clinical symptoms appear — and receive appropriate education and counselling to prevent further spread of the virus as well as appropriate treatment and counselling to help the person maintain and enhance his or her health.

Since 1986, physicians in Ontario have been able to request HIV antibody tests non-nominally (using a code or the patient's initials rather than the patient's name). However, physicians were still legally required to report the name and address of anyone who tested positive (i.e., anyone infected with an agent of a communicable disease). In practice, many medical officers of health would request names and addresses only when they and the physicians felt the person posed a threat to others but, under the law, medical officers of health could always require a physician to provide the patient's name and address. In addition, any physician who did not routinely report names and addresses was breaking the law.

Because of stigma still associated with HIV disease, privacy and confidentiality are extremely important to people who are or may be infected. Although there has never been a breach of confidentiality within the public health system in Ontario, the fear of a possible

breach led many people with HIV to object to the nominal reporting requirement.

The ministry became convinced that the reporting requirement was keeping some people at risk from being tested. To achieve its goal of bringing people at risk into the health care system, the ministry made two significant changes to its HIV testing policy:

- On January 1, 1992, the ministry introduced anonymous HIV antibody testing. # sites across the province have been designated to offer anonymous testing and are exempt from the reporting requirements under the Act
- On (date), the ministry made amendments to regulation 490/85 of the Act to allow physicians who choose to do so to offer their patients non-nominal as well as nominal HIV antibody testing.

Principles

The system of non-nominal HIV antibody testing described in these guidelines is designed to:

- safeguard the rights of the infected person to privacy and confidentiality
- respect the doctor-patient relationship
- continue to protect the public from the spread of HIV infection

It is based on the following principles:

- The confidentiality of personal information should not be compromised unless there is a threat to public health. If patients tested non-nominally are willing to help notify their sexual and drug partners and to take precautions to protect others, then their names will not be reported to the medical officer of health.
- People who have been exposed to the virus have a right to know they have been exposed so they can make informed decisions about seeking early testing and treatment.
- The majority of people diagnosed with HIV infection recognize their responsibility to prevent further spread of the virus and to help notify past contacts. The number who are either unwilling or unable to notify partners or to take precautions and who pose a risk is very small. For this reason, the system for non-nominal testing and reporting will be the least intrusive possible, while still safeguarding the public's health. Coercive measures will be used only as a last resort.

- An effective system of non-nominal testing and reporting depends on the goodwill and co-operation of all involved. It is based on a co-operative relationship between the patient and doctor, and with the community-based agency when involved, and on a supportive/co-operative relationship between the doctor and medical officer of health.
- A person infected with HIV goes through a difficult process of coming to terms with a positive diagnosis, changing behavior to enhance his or her health and protect the health of others, and dealing with disclosure and partner notification. This process takes time and requires ongoing support and encouragement, which is most often found either in a patient-physician or client-counsellor relationship.
- A person infected with HIV will be an active participant in his or her care, and will be fully informed about the requirements for non-nominal reporting and about any concerns the physician may have about their behavior and their ability to fulfill the requirements.
- The decision to report the name and address of a patient will be based on behavior, not HIV status or sexual orientation.
- The system for non-nominal testing and reporting will not undermine the anonymous testing system already established in Ontario.

Roles and Responsibilities

With non-nominal testing and reporting, the responsibility for assessing a patient's ability to meet the requirements rests with the physician, and becomes part of ongoing patient care.

Role of the Physician in Non-nominal Testing and Reporting

- To encourage people who are involved in risky activities to consider being tested.
- To explain the three testing options available in Ontario — anonymous, non-nominal and nominal.
- To ensure that anyone who seeks testing receives high quality pre- and post-test counselling about the risks of transmission and the means to prevent the spread of the virus.
- To order the HIV antibody test.
- To assist the person who tests positive in working through the difficult process of coming to terms with a positive diagnosis, changing behavior and maintaining the behavior change, and notifying past partners.
- To use his or her knowledge and personal/clinical assessment of the patient to determine whether, in his or her behavior, the patient meets the criteria for the reporting exemption.
- To accept the ongoing responsibility for monitoring the patient, and any changes in health or behavior that could affect the person's continuing ability to meet the requirements for non-nominal reporting.
- To provide to the medical officer of health epidemiological information on all patients with HIV infection including: the patient's initials, sex and date of birth, including year of birth, and risk factor(s) for HIV infection. This information will be used to follow HIV disease in Ontario and plan appropriate services.
- To report the name and address of any HIV-infected patient whose behavior poses a risk to others.

Role of the Medical Officer of Health

- To support and assist the physician and/or the patient in their efforts to fulfill the requirements for non-nominal reporting.

Role of the Person Seeking Testing

- To be aware of the three available testing options, and to make an informed decision about the type of testing that is best for him or her.

Role of the Person Infected with HIV

- To play an active role, working with the physician to ensure that all requirements for non-nominal testing and reporting are fulfilled.
- To integrate the information provided during counselling sessions into his or her life, changing behavior when necessary to enhance his or her health and to protect the health of others.
- To satisfy his or her physician that he or she has fulfilled the requirements for non-nominal reporting.

Guidelines for Physicians for Non-nominal Testing and Reporting

1. Encourage people at risk to be tested.

In the course of providing care, physicians should encourage any patient involved in risky activities to consider being tested, including:

- a man who has had unprotected sex with another man anytime since 1980
- a man who has had protected or unprotected sex with a man who was infected
- anyone who has shared needles to inject drugs
- anyone whose sexual partner has tested positive
- a woman whose sexual partner has had sex with men
- anyone (including prostitutes) who has had multiple partners
- anyone who is uncertain about their partners' past activities
- anyone with clinical signs and symptoms of another sexually transmitted disease
- anyone who has clinical signs and symptoms associated with HIV infection
- anyone who had a blood transfusion before November 1985
- anyone who has had an occupational exposure to HIV

For patients, the benefits of HIV antibody testing and early diagnosis are:

- an end to the anxiety of not knowing their HIV status
- the ability to use that knowledge to be more in control and take charge of their life and health
- access to medical care and treatment, including prophylaxis and other therapies that help patients maintain their health, delay disease progression and remain asymptomatic
- access to psychosocial support
- access to counselling that will reinforce the importance of practicing safer sex and preventing further spread of the virus

2. Explain the testing options

Anyone seeking HIV testing has the right to know his or her options. Physicians have a responsibility to describe the three options:

- anonymous testing — offered at certain designated clinics; no names or any other identifying information is collected; the blood test is ordered using a code; only the patient knows the code.
- non-nominal testing — offered by **some** physicians; the physician knows the patient's identity, but orders the test using a code; only the physician can link the code with the person; if the person tests negative, no report is made; if the person tests positive, the case is reported, but the physician does not have to report the name or any identifying information as long as the patient fulfills certain requirements to protect the health of others.
- nominal testing — offered by physicians; the test is ordered using the patient's name; if the person tests negative, no report is made; if the person tests positive, the physician is obliged by law to report his or her name and address to the medical officer of health, who is required by law to keep this information strictly confidential.

The clinics designated to offer anonymous testing (as at [date]) are listed on page #. For information on any newly designated clinics, contact the AIDS hotline at:

Physicians who choose not to offer non-nominal testing have a responsibility to ensure their patients are aware of the other options and how to access them. They may also choose to refer to a physician who will test patients non-nominally.

3. Ensure the patient receives high quality pre- and post-test counselling

The physician can either provide pre-test counselling personally or refer the person to a community-based organization or counselling service with expertise in this area. The decision should be based on providing the best quality service (i.e., physicians who see few patients requesting HIV antibody tests may not be as experience or as familiar with the counselling issues).

Counselling is an interactive process — not simply one person giving information to another, but an open discussion of issues, feelings, concerns and reactions. Counsellors are expected to bring their own knowledge of counselling skills to the sessions, adapting the

information — if necessary — to meet the clients' needs. Counsellors are reminded that culture, language, perception of HIV disease, the person's self-esteem and many other factors will have an impact on how clients understand and are able to act on the information they receive. These should all be taken into account in the counselling sessions.

Pre-test counselling should cover the following:

- reasons for seeking testing
- how the virus is transmitted (including the "window" period between infection and the time the body develop antibodies)
- an assessment of the person's risk and whether testing is indicated
- how to prevent the spread of the virus (i.e., safer sex and drug use)
- the importance of protecting his or her own health, and of protecting sexual partners
- the type of information the test provides and how to interpret that information
- the implications of a positive test result and the patient's likely reaction to it

A number of different guidelines for pre-test counselling are available and are listed on page #.

4. Order the test.

Drawing the blood. Physicians who choose to offer non-nominal testing must draw the blood themselves or have it drawn within their offices. Patients cannot be referred to blood drawing services because these services must have a health insurance number and will have access to the patient's name.

Coding the form. Physicians who choose to offer non-nominal testing will submit the HIV serology requisition form using a code instead of the patient's name. Over the past seven years, the Central Public Health Laboratory has reported serious problems with coded requisitions. Physicians often forget the codes they have used and, on several occasions, have been unable to trace a patient to give the results or have given results to the wrong patient.

To avoid these kinds of serious administrative problem, the ministry recommends that physicians use the initials of patient being tested.

Completing the form. HIV antibody tests will be completed only when all the required information on the form is complete, including: age, sex, birthdate, patient risk(s), symptoms/diagnosis, whether or not the person has been tested before.

5. Work with the HIV Positive Patient to Fulfill the Requirements for Non-nominal Reporting

As stated before, coming to terms with a positive diagnosis is a process. It takes time, support and encouragement. Many people who have HIV disease report that they absorb little information during their post-test counselling session beyond the fact that they are infected. It is only after some time has passed that they are able to accept and deal with the need to change their behavior to protect their own and their partners and to help ensure past partners are informed that they may have been exposed.

The amendment to regulation 490/85 gives patients and their physicians a period of 60 days to work through these issues. By the end of that time, the physician must have no reason to believe the person will expose others to infection, and the physician must be satisfied that identifiable partners have been notified and that the person has received counselling about preventing the transmission of HIV infection.

No reason to believe the person will expose others to infection with an agent of AIDS

To determine whether or not the patient fulfills this requirement, the physician must do a personal and clinical assessment, and have some specific evidence that the person's behavior poses a risk, including:

- an explicit refusal to receive post-test counselling
- an explicit refusal to make appropriate changes in his/her behavior (e.g., refusing to practice safer sex)
- an explicit refusal to inform partners
- clinical evidence that the person is not practicing safer sex (e.g., the person presents with another sexually transmitted disease or the person is identified as a contact of someone who was exposed and became infected positive after the person knew his/her HIV status)

- the presence of other medical problems that might impair judgement (e.g., dementia, psychosis)
- a serious substance abuse problem that might impair judgement (e.g., drug or alcohol addiction)

If, on the basis of his/her assessment, the physician has reason to believe the person will expose others and is a serious risk, he or she is required to contact the medical officer of health immediately.

If, however, the physician has reason to believe that — with proper counselling and support — the person will be able to comply with the requirements, he or she has 60 days to pursue that kind of supportive program.

Is satisfied that each identifiable person who may have been exposed has been notified

Ontario's partner notification policy is based on "the principle that individuals who may have no reason to suspect they may have been exposed to HIV should have the opportunity to know that they may have been so exposed" (National Advisory Committee on AIDS, 1987). They can then make their own informed choices about seeking counselling or testing. If they are not infected, they can get the information they need about safer sex and drug use to protect themselves in the future. If they are infected, the sooner they know the more likely they are to stay healthy and prevent further spread of the virus.

Most people with HIV infection agree that partners should be notified, but they find it a very difficult task to do. Within the context of non-nominal testing and reporting, the role of the physician is to encourage and promote partner notification, and ensure their patients have the assistance they need. To that end, physicians will discuss with patients the benefits and importance of partner notification, including:

- it allows partners who are infected to seek early care and treatment and maintain their health
- it may keep partners who are unknowingly infected from spreading the virus to others
- it gives partners the ability to make their own informed choices and decisions

Patients who are at first opposed to notifying their partners may, with proper counselling and education, come to accept its importance and play an active role. The non-nominal testing and reporting system provides four possible means of notifying partners:

- the physician contacts and counsels the partners
- the patient him/herself takes responsibility for notifying partners, and then satisfies the physician that this has occurred
- either the physician or the patient seeks assistance from the medical officer of health/public health system (This can still be done non-nominally: the physician or patient can provide the names of partners without revealing the patient's identity.)
- a combination of the other three

Physicians who choose to offer non-nominal testing must decide the extent to which they wish to be involved in partner notification and inform their patients accordingly. For example, some physicians may be willing to do the work to track down contacts, some may be willing to notify and counsel any contacts who are already part of their practice, and others may feel they do not have the competence or experience to provide this service and that it is better done by trained and experienced public health nurses.

In any case, the physician must ensure the patient is aware of his/her preferred approach to partner notification.

i. Identifying Partners

The physician should encourage the patient to recall all partners or contacts after their approximate date of infection. If it is not possible to establish a date of infection, clients should consider all unsafe sexual and needle use partners since 1980 — including women who now have young children. To help clients decide who needs to be notified, the physician can define a "partner":

- someone who has engaged in unprotected penetrative sex or shared needles with the client
- someone who has engaged ***frequently*** in protected penetrative sex with the client
- someone who has engaged in any sexual or drug use activity with the client where the risk is uncertain

Patients should be asked to identify all possible partners. The only exceptions include totally anonymous partners and partners whose identification is so sketchy that identification is very unlikely.

ii. Contracting the Responsibilities

Once the patient has identified his or her partners, the physician can use the "contract" form on page to help establish partner notification responsibilities. For example, the patient might agree to notify two or three partners he or she knows and still sees; the physician might agree to notify two partners who are in his or her practice; and the patient and physician might agree that the other names will be given to the public health department for follow up. In some circumstances (e.g., when the patient does not know the partner's name but can provide a useful description; when the partner lives in another geographical area where it is unfeasible for the patient or the physician to do the notification.

Both the patient and physician will sign the contract and agree to fulfill the responsibilities by a certain date (i.e., 60 days after diagnosis). During subsequent visits, the physician can use the contract as a means to reinforce the importance of partner notification and to keep track of progress.

iii. Strategies for Partner Notification

If clients are uncomfortable about notifying their partners, the physician can help by discussin possible strategies that can reduce the stress, including:

calling the partner on the phone or writing a note rather than having a face-to-face meeting

bringing the partner to his/her next appointment with the physician so the physician can help explain the implications

making it easier to tell past or current partners face to face by

- choosing a comfortable, safe environment
- being prepared with written information about HIV infection or with a number the partners can call for more information

- being prepared for a variety of reactions from partners

iv. Satisfying the Physician

Under the amended regulation, the physician must be satisfied that partner notification has occurred. If the physician notifies the partners him or herself or, at the request of the patient, passes the names to public health, then he or she has fulfilled this obligation.

However, when the patient agrees to notify some or all contacts, the physician may ask for some form of confirmation that partner notification has occurred. This could include:

- a discussion of how and when a partner was notified and his or her reaction (The physician can then summarize this in notes on the chart or on the contract.)
- cards with a code the physician can link with the patient, which the patient gives to contacts, who then mail them back to the physician's office (Because some contacts will neglect to mail the cards, the physician can assume that a return rate of #% means that partner notification has occurred.)
- cards with the physician's phone number on it that the patient gives to contacts; contacts are then asked to call the physician and confirm they have been notified; in this situation, the physician can also help contacts seek appropriate testing services or medical care — if requested (Because some contacts will neglect to call, the physician can assume that a call rate of #% means that partner notification has occurred.)

With any of these approaches, there is an opportunity for patients to cheat the system if they choose to do so. Therefore, the physician will also use his or her personal subjective knowledge of the patient in determining whether or not partners have been notified.

Even when there is some doubt, the physician's approach should continue to be co-operative and not cohersive. The goal is to gain and maintain the patient's trust in the system. Without the patient's goodwill and co-operation, partners cannot be identified or notified.

This phrasing stuff is just bizarre

v. Satisfying the Medical Officer of Health

The Ministry of Health recognizes that partner notification is difficult, and that it may be impossible for physicians to confirm that all identifiable contacts have been notified. If the physician is satisfied that at least #% of identifiable contacts have been notified, then that will satisfy the medical officer of health. When the physician and/or patient have made all possible efforts to contact a partner, but have been unsuccessful, then the reporting exemption will apply.

If after the 60 days, the physician has not been able to satisfy him or herself that partner notification has occurred, he or she should discuss the case (without revealing the identity of the patient) with the medical officer of health who may be able to suggest other approaches. If that fails, the physician is required to report the name and address of the person with HIV to the medical officer of health. Public health nurses will then try to work with the person to identify and notify contacts.

Is satisfied that the patient has received counselling about preventing the transmission of HIV infection

To meet the requirements for non-nominal reporting, the physician is must be satisfied that the patient has received counselling to prevent transmission. Physician who are experienced with HIV disease may choose to do the counselling personally. Physicians who are not experienced or who are not comfortable providing the education or counselling required can refer the patient to:

- another physician who is more experienced with HIV
- a community-based AIDS organization or other experienced counselling service
- public health staff

If the physician does refer the patient for counselling, he or she will confirm that counselling has occurred.

Counselling to prevent HIV transmission will include:

- the high risk of transmission through sexual intercourse or needle sharing,
- risk reduction activities (e.g., safer sexual practices, the use and efficacy of condoms and needle sterilization techniques)

- reproduction outcomes for women of child-bearing age, as well as for men, and
- support programs available that can help empower people to change their behavior to prevent HIV transmission

Report the patient's initials, sex and date of birth, including year of birth

The physician will explain to the patient that, to monitor the spread of the disease and plan services, it is necessary to collect certain non-identifying information including: the patient's initials, sex and date of birth, including year of birth.

By providing initials and date of birth, the patient can ensure that he or she is not being counted more than once in the statistics for HIV infection.

Physicians will complete the reporting form and submit as soon as possible to the local medical officer of health; to be exempt from nominal reporting, this information must be provided by the end of the 60 day period.

6. Report the name and address of a patient who does not fulfill the requirements for non-nominal reporting

If the physician has reason to believe the person poses a risk to others, or is not satisfied the person has been appropriately counselled or his/her partners have been notified, then the physician will contact the local medical officer of health and discuss the case — without revealing the patient's identity.

The physician and medical officer of health will review the process that has occurred so far, and determine if any other means might be used to gain the patient's trust and co-operation. If this also fails, the physician is obliged to report the person's name and address, the medical officer of health or his/her designate will take over responsibility for working with the patient.

Special Situations

1. The patient has previously been tested anonymously

The non-nominal testing program should not undermine Ontario's anonymous testing program.

In anonymous testing, the patient is required to have both pre- and post-test counselling, and is asked to notify his or her partners.

When someone who has been tested anonymously seeks the care of a physician, the physician will:

- confirm that the person has been counselled and has understood the information provided (Many people with HIV report that all they remember from their post-test counselling session is that they tested positive. The physician may have to reinforce the prevention information or may refer the patient for some ongoing counselling to help the patient cope with the diagnosis and the changes now required.)
- reinforce again how important it is to notify partners; ask the patient whether partners have been notified and offer the same assistance or approaches recommended above

2. The patient has previously tested positive for HIV antibody while in the care of another physician

The physician should determine the circumstances of the earlier test. If he/she or another Ontario physician has been satisfied that the criteria for non-nominal reporting have been met and the physician has no information about new partners or new risky activities, then the exemption applies.

If the previous test was performed by a physician but the criteria outlined above were not met, then the process described above should be followed and the criteria must be met to qualify for the exemption.

3. The MOH and the reporting physician disagree about whether the report qualified for the nominal reporting exemption.

It is expected that in the vast majority of reports the MOH and the physicians will be in agreement. However, there is some judgement

required from the MOH and on occasion there may be disagreement about the need for nominal reporting. In these circumstances, the MOH should, at a minimum, consult with the Chief MOH before requiring reporting.

Guidelines for Medical Officers of Health

The medical officer of health plays a key role at four stages in the process of non-nominal testing and reporting:

- at the beginning of the 60 day period, when the positive test result is first received
- during the 60 day period when the physician and patient are working together to fulfill the requirements for non-nominal reporting
- at the end of the 60 day period, when the ongoing exemption is granted
- when a physician reports someone who has not fulfilled the obligations for non-nominal reporting

At the beginning of the 60 day period

A medical officer of health will receive a report from the Public Health Laboratory or physician, that a physician has an unnamed patient with HIV antibody. The medical officer of health or his/her designate will then contact the physician to discuss the conditions that must be met for the physician to be exempt from nominal reporting.

The medical officer of health will ascertain if the physician has any reason to believe that the infected person poses an immediate danger:

- If the physician feels that, because of his or her behavior, the infected person poses an immediate danger, the medical officer of health will discuss the case and the physician's reasons for forming his or her opinion. Criteria for finding someone poses a risk include:
  - an explicit refusal to receive post-test counselling
  - an explicit refusal to make appropriate changes in his/her behavior (e.g., refusing to practice safer sex)
  - an explicit refusal to inform partners
  - clinical evidence that the person is not practicing safer sex (e.g., the person presents with another sexually transmitted

disease or the person is identified as a contact of someone who was exposed and became infected positive after the person knew his/her HIV status)

- the presence of other medical problems that might impair judgement (e.g., dementia, psychosis)
- a serious substance abuse problem that might impair judgement (e.g., drug or alcohol addiction)

- If, together, the physician and medical officer of health agree that further counselling or education will not eliminate the risk, then the medical officer of health will ask for the patient's name and address.
- If the physician does not feel the infected person poses an immediate danger, the medical officer of health will tell the physician that he/she will be contacted again in sixty days, to ensure that the patient has cc-operated with the requirements for non-nominal reporting.

The medical officer of health will request the epidemiological information required to monitor the spread of HIV disease including: the patient's initials, sex and date of birth, including year of birth.

After this initial contact with the physician, the medical officer of health may also send the physician a letter outlining the requirements for non-nominal reporting.

During the 60 day period

During the 60 day period, the medical officer of health will offer any form of support or assistance the physician or patient may need, and encourage the physician to call anytime if he/she has any questions or concerns.

If requested by the physician or the patient, the medical officer of health or his/her designate will actively help notify partners and/opr provide any counselling services required.

At the end of the 60 day exemption period

The medical officer of health or his/her designate will contact the physician at the end of the exemption period (60 days) to ensure that the physician is satisfied that the patient has met the requirements for non-nominal reporting.

The medical officer of health or his/her designate may ask the physician to discuss in some detail the basis on which he/she decided whether or not the person fulfilled the obligations for non-nominal reporting and will ensure:

- the person does not pose a risk to others
- at least #% of identifiable contacts have been notified
- the person has been counselled to prevent the spread of HIV

In cases where the person meets the criteria for non-nominal HIV reporting and at the same time meets the AIDS case definition, then their name and address will not be required on the AIDS case reporting form.

If the physician has any ongoing concerns, the medical officer of health will discuss them, and together agree on a course of action that will be most beneficial to the patient and to the public's health.

In the event of a disagreement between the medical officer of health and the physician about whether or not the physician qualifies for the exemption, the Chief Medical Officer of Health should be consulted before any further action is taken.

Recognizing the changing nature of HIV disease, the medical officer of health will encourage physicians to report any changes in their patient's health status (i.e., development of dementia) that might pose a risk to the community.

When the physician reports a patient who has not fulfilled the obligation for non-nominal reporting

At anytime during the 60 day period and after, a physician may decided — based on clear evidence — that a patient either has not fulfilled or is no longer fulfilling the obligations required for non-nominal reporting. In that case, the physician is required to report the person by name to the medical officer of health.

In that situation, the medical officer of health will:

- discuss the case with the physician, including the physician's reasons for wanting to report by name (before allowing the physician to provide the name)

- if the physician believes the person poses a risk to others, the medical officer of health will ensure the physician has used clear, objective criteria as the basis for his/her assessment
- in difficult cases, the medical officer of health will consult with his/her colleagues, AIDS experts, community groups and the Chief Medical Officer of Health
- if, based on this consultation, the medical officer of health agrees with the physician that the patient poses some risk to others, then the medical officer of health will take the person's name and address
- the medical officer of health or his/her designate will then contact the person and begin a process of working with the person to prevent the spread of HIV disease
- people who require longer term counselling or other services not available through the public health system are to be referred accordingly.