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SEX, LIES, AND HIV: *MABIOR* AND THE CONCEPT OF SEXUAL FRAUD

This article argues that the Court missed an opportunity to reconsider the test for sexual fraud it had laid out in its 1998 decision in R v Cuerrier, *a test that since its inception has proven difficult to apply. It argues that the standard in* Mabior *is unlikely to provide people living with HIV and other sexually transmitted infections the certainty lacking under* Cuerrier *and that the judgment fails to advance the development of the concept of consent in the law of sexual assault.*

Keywords: sexual assault, consent, fraud, HIV, sexually transmitted infections (STIs).

From almost any perspective, *Mabior* and *DC* are profoundly disappointing judgments. They fail to provide clear guidance to those living with HIV as to when disclosure is necessary, and they fail to give guidance on disclosure to those living with other sexually communicable diseases. Perhaps most fundamentally, they fail to address whether the 'significant risk of serious bodily harm' test for fraud in the sexual context, set out in the *Cuerrier* decision, provides a workable definition of fraud. To explain these criticisms, I return to the Court's judgment in *Cuerrier*, where the issues that gave rise to these problems are addressed more clearly.

Cuerrier forced the courts to confront an extraordinarily difficult issue – how to interpret the concept of fraud in the context of sexual consent. Fraud is relevant to the offences of assault and sexual assault because of the way those offences are defined in Canadian law. Section 265 of the *Criminal Code*, which forms the basis of the *actus reus* of assault and sexual assault, provides that a person commits an assault when he or she applies force to another person without consent.[1] Section 265 goes on to provide that no consent will be obtained where the complainant submits or does not resist by reason of four factors: (1) the application of force; (2) threats or fear of the application of force; (3) the exercise of authority; or (4) fraud. These provisions have been interpreted to mean that touching will be assaultive (regardless of the degree of force applied) unless the person who is touched has given consent. Even if that person has 'consented,' the consent he or she has given will not be

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1 These provisions are supplemented for sexual assault by the provisions found in *Criminal Code*, RSC 1985, c C-46, ss 271–273.3.

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valid if it was obtained through the use of – or threats of – violence, the exercise of authority, or (most relevant here) fraud. The question that arises, here, is what types of fraud will invalidate consent to sexual touching. Will any deception that leads to consent be enough? Or will only certain types of misrepresentations vitiate consent to a sexual encounter?

Before *Cuerrier,* the answer to this question was clear. In the context of sexual consent, the law limited fraud to two types of misrepresentation: deceptions going to identity and deceptions going to the nature and quality of the act. Both of these types of fraud were interpreted narrowly. Misrepresentations as to identity were limited to situations where the accused impersonated another person, as when the accused impersonated a woman's husband. They did not include false claims about status (e.g. I'm a doctor), accomplishments (I was a member of the Olympic boxing team), or personal attributes (I'm a good listener) that a person might make as a way of attempting to convince another to engage in a sexual encounter. Misrepresentations as to the nature and quality of the act were limited to claims that a sexual act was actually something else and non-sexual, such as a claim that sexual intercourse was really a medical treatment.[2] Since the1888 English decision in *R v Clarence*[3] it had been clear that lying about having a sexually transmitted disease did not constitute fraud. According to the *Clarence* court, so long as the complainant understood that she was consenting to a sexual act, the accused's failure to disclose a sexually transmitted disease did not affect the validity of the complainant's consent.[4] This was the state of the law at the time the Crown decided to charge Cuerrier with aggravated assault for failing to disclose to two women that he was HIV-positive.

The central issue at the Supreme Court of Canada was whether 'fraud' in the sexual context should continue to be limited to misrepresentations going to identity and to the nature and quality of the act, or whether fraud should be given a broader definition. This issue is much more difficult than it first appears. The difficulty arises from the challenge of finding a principled yet workable definition of fraud in the sexual context, one that captures the kinds of deceptions that should give rise to liability for sexual assault without making everyone who lies in the prelude to a sexual encounter into a sex offender.

2 See e.g. *Bolduc v The Queen,* [1967] SCR 677.

3 (1888), 22 QBD 23.

4 These limitations on the types of fraud that invalidated sexual consent developed under the offences of rape and indecent assault, which no longer exist within Canadian law.

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Limiting fraud to the two highly circumscribed types of deceit recognized at common law provides a workable definition but one that seems unduly narrow. Arguably, deceptions beyond these categories are sufficiently fundamental to the nature of consent to vitiate consent to sexual activity. Deceptions about sexually transmitted infections (STIs) are a case in point. Lying about, or even failing to disclose, a sexually transmitted infection is a good candidate for the type of deception that should amount to fraud in the sexual context, since sexual infections are factors that might reasonably lead people to refuse consent. Deceptions about sexually transmitted infections do not affect the sexual nature of the act, but they do seem to go to the very heart of the conduct to which people consent when they engage in sexual activity.

But if fraud were to be expanded to allow a broader range of deceitful practices to vitiate consent, what other sorts of lies should count? Should all lies made in the hope of securing consent be treated as significant enough to invalidate consent? If, for example, the accused falsely represents himself as being a CEO of a major corporation or as a doctor, and the complainant consents in part as a result of that (mis)information, should the complainant's consent be seen as legally invalid? What if the accused tells the complainant, falsely, that he has had a vasectomy and she consents to unprotected intercourse as a result? Has she given legally valid consent?

While these examples may seem fanciful, similar questions have arisen in litigated cases. For example, in *R v Petrozzi*,[5] the British Columbia Court of Appeal was asked to determine whether a man who had promised to pay a sex worker for the performance of a sexual act, never intending to pay her, had obtained her consent by fraud. The Nova Scotia case of *R v Hutchinson*[6] raised the issue of the validity of a woman's consent to sexual intercourse in circumstances where her partner had, unbeknownst to her, pierced holes into the condoms they used for contraception. And in an Israeli case, an Arab man was convicted of the offence of 'rape by deception' for allegedly misrepresenting himself as being Jewish.[7] The complainant in the case, a Jewish woman, testified that she would never have had intercourse with the accused had she known he was Arab. Are these the sorts of misrepresentations that should make an otherwise consensual act nonconsensual?

5 (1987), 35 CCC (3d) 528 (BC CA).

6 *R v Hutchinson*, 2009 NSSC 51, rev'd 2010 NSCA 3, new trial, 2011 NSSC 361, aff'd 2013 NSCA 1, leave to appeal filed to Supreme Court of Canada on 10 January 2013.

7 See "'Israeli Arab who "raped" a woman says verdict "racist."' *BBC News* (21 July 2010) online: BBC News <http://www.bbc.co.uk/news/world-middle-east-10717186>. Sabbar Kashur had originally been charged with rape and indecent assault.

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If, instead, only certain lies should be recognized as amounting to consent-vitiating fraud, which lies should count? Is there a principled way of distinguishing between the types of misrepresentations that should invalidate consent and those that should not? How do we maximize protection of the complainant's sexual autonomy without turning all lies into sexual assaults?

While these concerns are important for the principled development of the law generally, they have particular resonance for feminists. For decades, feminist scholars and activists have pushed for reforms to the procedural, evidentiary, and substantive laws on sexual assault to remove stereotypes that treated sexual assault complainants with suspicion and to create new laws that took women's sexual autonomy seriously.[8] A considerable amount of this advocacy has centred on reformulating the concept of sexual consent. Feminists have fought for a concept of consent that maximizes women's ability to decide when, with whom, and under what conditions they will agree to sexual activity. These efforts are now reflected in s 273.1 of the *Criminal Code*, which defines consent as the voluntary agreement of the complainant to engage in the sexual activity in question, and by the Supreme Court of Canada decision in *R v Ewanchuk*,[9] which held that consent is determined based on the *complainant's* perspective.

The question of how fraud should be defined is inextricably linked to the definition of sexual consent and it is for this reason that the issue is so challenging for feminists. On the one hand, a broad definition of fraud appears most consistent with the enterprise of taking women's consent seriously because it recognizes that many factors can undermine a person's ability to give meaningful consent. But on the other hand, not all deceptions are so morally objectionable that they should brand the person who makes them with a sexual assault conviction. This is true even for deceptions about sexually transmitted infections. For example, lying about a yeast infection, while not laudable, does not evoke the moral opprobrium we associate with a sexual assault. Even deceptions about HIV provoke different moral responses, a point *Mabior* and *DC* illustrate well. There is a vast difference in the blameworthiness of someone like Mabior, who routinely had unprotected intercourse with teenage girls, and someone like DC, who may have performed one act of unprotected sex with a man with whom she was hoping to form a relationship and who, she likely was hoping, would not reject her once she

8 For a discussion of some of these laws, see Martha Shaffer, 'The Impact of the Charter on the Law of Sexual Assault: Plus ça change, plus c'est la même chose' (2012) 57 Supreme Court LR (2d) 337.

9 [1999] 1 SCR 330.

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disclosed. Treating them both as sex offenders does not take into account the significant moral difference in their actions. This suggests that sexual assault may be too blunt an instrument to deal with deceptions about HIV. Instead of treating these deceptions as a type of sexual fraud, a more nuanced approach may be needed.

Faced with these difficult questions, the Supreme Court of Canada in *Cuerrier* split three ways on the definition of sexual fraud. Justice L'Heureux-Dubé articulated the broadest approach, holding that fraud should include *any* deceit intended to secure consent that does, in fact, secure consent. This approach maximizes a person's ability to make accurate and informed choices about the conditions under which he or she will agree to sexual touching and seems the most consistent with the objectives underlying the offences of assault and sexual assault – protecting physical autonomy and integrity. But it also vastly expands the scope of sexual assault because any deception, no matter how trivial, will vitiate consent if the complainant would not otherwise have consented.[10] For precisely this reason, Justice Cory, for the majority, proposed a definition of fraud deliberately designed to narrow the scope of criminalization for sexual deception. For Justice Cory, sexual deception would amount to fraud only where it exposed the complainant to a 'significant risk of serious bodily harm.'[11] This limitation would permit the concept of fraud to be expanded while at the same time preventing lies that 'lack the reprehensible character of criminal acts'[12] from being swept within the sexual assault provision. Justice McLachlin (as she then was) proposed the narrowest approach. She held that, in addition to the two traditional categories, fraud should be expanded to include 'deception as to the presence of a sexually transmitted disease giving rise to serious risk or probability of infecting the complainant.'[13] Thus, in addressing the question of which kinds of lies should amount to fraud in the context of sexual behaviour, the Court proposed three different answers: all deceptions (Justice L'Heureux-Dubé), only deceptions about sexually

10 The effect of Justice L'Heureux-Dubé's broad definition of fraud in the HIV context is that disclosure would generally be required to avoid a sexual assault conviction, with the exception of cases where it would be possible to show that the complainant would have consented even if the accused had disclosed – i.e., non-disclosure played no causal role in the complainant's decision to consent. Failure to disclose an HIV infection before engaging in sexual activity would amount to fraud.

11 *R v Cuerrier*, [1998] 2 SCR 371 at para 128.

12 Ibid at para 133.

13 Ibid at para 70. Justice McLachlin made no effort to expand her test for fraud to lies falling outside of the context of sexually transmitted infections, holding explicitly that the question of whether other deceptions should be included within the definition of fraud was 'better left for another day'; ibid at para 73.

transmitted diseases where there is a high risk of transmission (Justice McLachlin), or only those deceptions which expose the complainant to a 'significant risk of serious bodily harm.'

Although Justice Cory's test might appear to set out a solid middle ground between Justice L'Heureux-Dubé's broad approach and Justice McLachlin's narrow one, problems of application began to surface almost immediately after its inception. Most of these focused on the requirement that there be a 'significant risk' of harm and more specifically on the question of how to determine whether a risk is 'significant.' Even in the HIV context, the very context in which the 'significant risk' test was born, these issues proved problematic. In *Cuerrier* itself, Justice Cory assumed that unprotected vaginal intercourse always posed a 'significant risk,' an assumption that makes the 'significant risk' test easy to apply. But since *Cuerrier*, research has established that the risk of transmission from unprotected intercourse is much lower than commonly thought and can be so low that it cannot be said to be 'significant' on any meaningful understanding of that word. For example, a person with an undetectable viral load has less than a 1 in 10 000 chance of infecting his or her partner through unprotected intercourse. Is this a 'significant risk' in any meaningful sense of that term?

Increased scientific knowledge of HIV transmission rates and of the factors that affect these rates raises uncomfortable questions for the 'significant risk' test. Research has shown that the risk of HIV infection is mediated by many factors, including stage of the infection, type of sexual activity, whether the person living with HIV/AIDS (PHA) is the insertive or receptive partner, condom use, viral load, anti-retroviral treatment, circumcision, and whether either partner has an STI.[14] Should the 'significance' of a risk be determined based on the likelihood of transmission? If so, how high must the transmission risk be to be considered significant? Since multiple factors affect the likelihood of transmission, how should a PHA – or a court – go about quantifying the risk? An accurate assessment would require that all of the relevant risk factors be considered, but if all of the factors have to be considered each time a PHA has sex, how workable is the 'significant risk' test? Does a test that

14 See David McLay, 'Scientific research on the risk of sexual transmission of HIV infection on HIV and on HIV as a chronic and manageable infection.' Report prepared for the Canadian HIV/AIDS Legal Network (December 2011), online: Canadian HIV/AIDS Legal Network at 9–12, 14–5 <http://www.aidslaw.ca/EN/lawyers-kit/documents/2a.McLay2010_s.3update-Dec2011.pdf>. Note this report is an update of section 3 of a report funded by the Ontario HIV Treatment Network: Eric Mykhalovskiy, Glenn Betteridge, & David McLay, HIV Non-Disclosure and the Criminal Law: Establishing Policy Options for Ontario (August 2010), online: <http://www.catie.ca/pdf/Brochures/HIV-non-disclosure-criminal-law.pdf> [McLay].

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requires this level of quantification provide enough certainty for a PHA to know in advance of engaging in sexual activity whether disclosure is required, especially in light of rapidly changing scientific knowledge about HIV transmission? Would a court also have to engage in this same type of analysis, looking back at each sexual encounter in order to determine whether the accused should have disclosed an HIV infection at that time?

These difficulties of application point to an even more fundamental question – whether the 'significant risk of serious bodily harm' test succeeds in distinguishing deceptions that should be treated as sexual fraud from those that should not. If the test is so difficult to apply in the very context that created it, how useful is it in delineating the kinds of deceptions that should be criminalized from those that should not?

In *Mabior,* the Supreme Court had the opportunity to revisit Justice Cory's 'significant risk of serious bodily harm' test and, in fact, it had been specifically asked to do so by the Manitoba Court of Appeal and by the Quebec Court of Appeal in *DC.* The Supreme Court ducked the issue. Instead, it reiterated the utility of the 'significant risk' test, asserting that the test 'carved out the appropriate area for the criminal law' by recognizing that 'not every deception that leads to sexual intercourse should be criminalized, while still according consent meaningful scope.'[15] The Court acknowledged that the application of the 'significant risk' test had generated considerable uncertainty as to when a person was required to disclose an HIV infection but held that the answer to this problem was to clarify how the test applies in the context of HIV. According to the Court, in the HIV context, a 'significant risk of serious bodily harm' will exist so long as there is a 'realistic possibility' of transmission.[16] There will be a 'realistic possibility' of transmission during (vaginal) sexual intercourse unless the accused has a low viral load at the time of the activity *and* condoms were used during the encounter.[17]

What are the implications of this 'realistic possibility' standard? Does it succeed in providing certainty to people living with HIV as to when they need to disclose their illness? Does it give any guidance at all to people living with other sexually transmitted infections?

The first point to make about the standard is that it is clearly a *legal* standard, not a medical one. As Alison Symington explains in more detail, from a medical perspective, the use of condoms *alone* would be sufficient to negate a 'realistic possibility' of transmission, and

15 *R v Mabior*, 2012 SCC 47 at para 58 [*Mabior*].
16 Ibid at para 84.
17 Ibid at para 94.

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transmission is considered very unlikely where a person has a low viral load.[18] The Court, however, insisted on *both* of these factors. In reality, the Court's 'realistic possibility' standard is far more stringent than its nomenclature suggests and more akin to holding that disclosure is required if there is more than a negligible risk of transmission.

Second, the need for the accused to have a low viral load raises problems of certainty and proof. Low viral load is central to establishing or negating liability and yet the Court spends virtually no time discussing what level counts as 'low.' The only indication the Court gives is in a single sentence where, based on the evidence led at trial, it discusses the impact of treatment on viral load: '[w]hen a patient undergoes antiretroviral therapy, the viral load shrinks rapidly to less than 1,500 copies per millilitre (low viral load), and can even be brought down to less than 50 copies per millilitre (undetectable viral load).'[19] If this number, 1,500 copies per millilitre, is to be the benchmark, more sustained discussion of this standard, beyond a passing reference, would be helpful. But, more importantly, how will a person know whether his or her viral load falls under this level? Viral loads are not tested on a daily basis and the frequency of testing will vary from patient to patient. If a PHA's last test was a month before a sexual encounter, can she rely on that result as a measure of her viral load? What if the last test was three months, or even six months before a sexual encounter? Since viral load can change over time and can be subject to 'spikes' due to other infections, how stable must a person's viral load readings be before he or she is entitled to rely upon them? Must a person with a low viral load give evidence that he or she did not have any condition that could have caused a 'spike'? Over time, courts can answer these questions, but until they do, people living with HIV are left with considerable uncertainty. Until this uncertainty is resolved, the safest course for avoiding liability is to disclose before any sexual encounter.

Third, it is not clear how this 'realistic possibility' test applies to sexual activities other than vaginal intercourse. For oral sex, the risk of transmission is so low that studies have not been able to obtain an accurate measure.[20] Must a person with HIV have a low viral load and use condoms during oral sex to avoid liability on the basis of non-disclosure? On the flip side, anal intercourse has a higher rate of transmission than vaginal intercourse, particularly where the insertive partner is HIV-positive.[21] Will low viral load and condom use negate the existence of 'realistic possibility' of transmission in these circumstances?

18 Alison Symington, 'Injustice Amplified' 63 UTLJ 485 at 488–490 [present issue].
19 *Mabior*, supra note 15 at para 100.
20 McLay, supra note 14 at 8.
21 McLay, ibid at 9.

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Finally, because it was devised specifically to address the application of the 'significant risk' test to HIV, the 'realistic possibility' test offers no guidance on the application of that test to people living with other sexually transmitted conditions. Though most sexually transmitted infections are treatable and not life threatening, many pose a risk of serious bodily harm. This is certainly true of gonorrhea, especially in light of the recent emergence of severe antibiotic resistant strains.[22] Even genital herpes, for which there is no cure, may be seen to pose a risk of serious bodily harm because of the possibility of recurrent outbreaks of painful sores. Does the Court's insistence that the 'realistic possibility' standard only applies to HIV mean that a different standard of disclosure applies to these conditions? Is disclosure warranted only where the transmission risk is *higher* than a 'realistic possibility'? What is the disclosure standard here?

In the end, the *Mabior* decision seems to fail on its own terms. By including low viral load within the 'realistic possibility' assessment it fails to provide the certainty that was missing from the 'significant risk' test. It fails to help us identify whether deceptions about other sexually transmitted illnesses amount to fraud that vitiates consent. And it fails to help us consider whether *Cuerrier*'s 'significant risk' test sets out a notion of sexual fraud that promotes a full conception of sexual autonomy and sexual consent.

22 See e.g. Centers for Disease Control and Prevention, 'Antibiotic Resistant Gonorrhea,' online: Centers for Disease Control and Prevention <http://www.cdc.gov/std/gonorrhea/arg/>; Robert D Kirkcaldy, Gail A Bolan, & Judith N Wasserheit, 'Cephalosporin-Resistant Gonorrhea in North America' (2013) 309 Journal of the American Medical Association 185.

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