# HIV Transmission, the Law and the Work of the Clinical Team, January 2013.

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## Contents

# 1. Introduction and Executive Summary

Prosecutions for reckless transmission of HIV have been brought in the UK since 2001 (Scotland) and 2003 (England & Wales). This has raised complex questions among medical practitioners as to their ethical and legal responsibilities related to HIV transmission, particularly around disclosure of information on HIV status. BHIVA and BASHH believe that this use of the law is unhelpful and potentially harmful to public health and support UNAIDS recommendations[1] to limit the use of criminal law and the Oslo declaration[2] view that a "non-punitive, non-criminal HIV prevention approach" is preferable.

However given the current legal position in the UK this document aims to provide information and guidance on managing issues related to sexual transmission of HIV based on current scientific evidence. Established generic ethical and professional principles continue to apply, but with greater emphasis on providing a confidential environment in which extremely sensitive matters can be frankly and fully discussed. This enables appropriate care of people with HIV and benefits public health by encouraging individuals to access testing and treatment. Within this framework this document sets out the roles and responsibilities of health care professionals when caring for individuals infected with HIV.

## 1.1 Who is this guidance for?

This guidance is aimed at those working in the field of HIV medicine, especially clinicians. There is specific guidance in relation to HIV disclosure for other groups of health workers, such as clinical psychologists[3] already in circulation. This guidance will also be of use to general practitioners, particularly section 1, figure 1 and table 1. It may also be useful for people living with HIV who want to understand the legal and medical basis for some of their care decisions.

## 1.2 Prosecutions

This document only sets out to deal with the issues surrounding the reckless transmission of HIV through sexual intercourse. Although there may be similar issues related to other sexually transmitted infections, blood borne viruses such as hepatitis B, and other routes of transmission, such as sharing syringes, they are not specifically addressed here. Reckless transmission is distinct from intentional transmission; intentional transmission occurs when someone with HIV is trying to infect someone on purpose, whereas reckless transmission occurs when someone with HIV is not taking care to prevent transmission to a sexual partner, but only when the sexual partner is not made specifically aware of the risk of infection.

In England and Wales a crime can only be said to have occurred if HIV is actually transmitted and individuals are only likely to be successfully prosecuted if there is evidence that they were reckless and that they were the only likely source of infection

In Scottish law transmission is not necessary and it is possible for individuals to be prosecuted for exposing someone to the risk of infection. However the Crown Office[4] has stated that prosecutions where no transmission has taken place would be exceptional. In either situation it is still necessary to prove recklessness

The legal position in Northern Ireland is essentially the same as England and Wales. Prosecution guidelines similar to those published by the CPS and Crown Office are being developed

Consistent condom use (even without disclosure of HIV status) could be considered a reasonable defence against recklessness.[4,5] To date this has not been authoritatively tested in court (see section 2.2a).

The use of condoms together with disclosure in the event of breakage to enable sexual partners to access post-exposure prophylaxis (PEPSE) is likely to represent a reasonable defence against recklessness. To date this has not been tested in court.

Scientific evidence alone is very unlikely to provide sufficient evidence that the defendant is the source of transmission; medical and factual evidence is also required.[4,5]

In most situations the appropriate use of antiretroviral treatment is at least as effective as condoms in preventing sexual transmission of HIV. This is accepted by the CPS and COPFS so it is likely that evidence showing that the defendant was taking effective antiretroviral treatment at the time of the alleged transmission may be used to demonstrate that they were not reckless.[4,5] To date this has not been tested in court.

### 1.3 Roles and responsibilities of Health Care Professionals.

Health care professionals have a central role to advise and support patients in decision making and to maintain confidentiality according to professional guidance and the law. Health care professionals must be mindful of their duty not to work beyond their expertise in legal matters.

For people with HIV, advice must include the routes of HIV transmission and how to prevent transmission, with information about safer sexual practices, the use of condoms and suppression of viral load. Advice must be given in a non-judgmental way. A discussion of sexual health needs must take place regularly, as indicated by a patient's lifestyle and according to BASHH guidelines.

There is individual and public interest in maintaining confidentiality; this may be outweighed in order to prevent serious harm to others.

It is important when considering breaching confidentiality to weigh up all potential harms as there may be situations where disclosure of HIV status to protect a sexual partner results in considerable harm to an individual e.g. domestic violence.

In situations where a health care professional believes that an HIV positive individual continues to put sexual contacts at risk their duties and subsequent action depend upon the type of contact (see figure one).

Health care professionals who do not work in an HIV service, including General Practitioners, should discuss cases of non-disclosure and alleged reckless transmission of HIV with an HIV consultant before taking any action or providing any information to the police.

No information should be released to the police unless patient consent has been verified or there is a court order in place, except in very limited circumstances defined by the GMC. Seek advice from relevant bodies if necessary, ensuring that the person giving advice has experience of this type of case.

It is up to an individual person to make a decision about complaining to the police that they have become infected with HIV, and health care workers should remain impartial during discussions with patients.

Those involved (complainant and defendant) in cases of reckless transmission are likely to need specialist legal advice and support and referral to 'THT Direct', the Terrence Higgins Trust helpline, would be appropriate

Sources of further information are listed at the end of this document.

### 1.4 Current Recommendation for Advice

**It is suggested that at the time of the writing, to help prevent transmission of HIV to sexual partners and to avoid prosecution for 'reckless' HIV transmission people with HIV should do at least one of the following:**

- **Use a male or female condom fitted correctly along with water-based lubricant. Individuals doing this are unlikely to be seen as reckless for legal purposes. In the event of a condom split, it is advisable to disclose HIV status in order to support the partner's decision whether or not to obtain post-exposure prophylaxis (PEPSE), which should be taken within 72 hours. The need for PEPSE will depend upon the type of sexual activity and the HIV viral load. An assessment of the risk should be undertaken by a clinician according to the BASHH PEPSE guidelines. Disclosure in these situations would suggest that the person with HIV was not reckless.**

- **Adhere to effective (suppressed viral load) antiretroviral medication. There is growing evidence of extremely low/minimal risk of transmission when plasma HIV is fully suppressed with the use of antiretroviral medication. In some situations an undetectable viral load can afford protection equivalent to or greater than that of condoms. A person with HIV is unlikely to be seen as reckless when relying on a suppressed viral load instead of condom use if they have been counselled accordingly by an HIV clinician or similar medical authority. It is recommended that this discussion is documented in the patient's medical records.**

**In addition people with HIV should be advised that disclosure of HIV positive status to a partner before sex is important to support informed agreement around risk and safer sex behaviours. To avoid successful prosecution an individual who is not taking effective antiretroviral medication and does not use a condom must disclose their HIV status to sexual partners before sex takes place.**

## 2.1 Current Law regarding reckless HIV transmission

Successful prosecutions for transmission of HIV have been brought in the UK since 2001 (Scotland) and 2003 (England & Wales).[6,7] It was formerly thought that the law (at least in England and Wales) did not cover the sexual transmission of disease. The charge used in England & Wales is inflicting "grievous bodily harm" under the 1861 Offences Against the Person Act,[8] sections 18 and 20. In Scotland the possible charges are the common law offence of assault (for cases of intentional transmission) or "culpable and reckless conduct". None of these charges were specifically designed to be used on sexual transmission of disease, although the courts consider this to be an appropriate use of the legislation. In Scotland, the most recent prosecution included charges of exposure alongside one of transmission. Prosecutions for exposure would not be possible under English law, except in the unlikely event that an intention to transmit HIV could be proven.

Charges are hard to investigate and even harder to prove, and the vast majority of allegations never reach court. Of those that do, however, there is a high rate of conviction and long prison sentences. Individuals convicted have also been subject to Sexual Offences Prevention Orders (SOPO), Antisocial Behaviour Orders (ASBO) or deportation. Even where the charges are dropped, police investigation of the allegations can be lengthy and personally highly damaging, usually involving extensive disclosure of status and detailed examination of sexual histories. Prosecutions to date in the UK have been predominantly against heterosexual men, a number of whom were migrants,[9,10] but can involve anyone with HIV.

There has been extensive work over the last few years by clinicians and community organisations with the Crown Prosecution Service (CPS) and the Association of Chief Police Officers (ACPO) in England and Wales and with the Crown Office and Procurator Fiscal Service (COPFS) in Scotland. As a result CPS, ACPO and COPFS have published guidance documents which clarify some parameters regarding prosecutions.[4,5,11]
Someone with HIV in England and Wales is only likely to be successfully prosecuted if they

- Knew they were HIV positive at the time of the alleged transmission
- Understood how HIV is transmitted
- Had unprotected sex with someone negative who subsequently tests positive and
- Did not disclose their HIV diagnosis before sex and
- Can be proven to be the only likely source of transmission.

In Scotland the position is broadly similar, however it is worth highlighting two different points in law discussed in the COPFS guidance:

- Someone with HIV could be prosecuted even if no transmission occurs, however the COPFS has stated that this "would only be contemplated in exceptional circumstances". Although there has already been a prosecution involving charges of exposure with no transmission, this was alongside one charge of reckless transmission; the exposure charges being used as additional evidence of reckless conduct.
- Consent to risk (by the claimant) is not a defence to reckless conduct in Scottish law. The COPFS guidance has clarified that for sexually transmitted infections it is highly unlikely that prosecution would take place where the claimant has freely given their informed consent to the risk of infection

Anyone making a charge needs to be prepared for close examination of their own sexual history, as well as that of the accused. It is for the prosecution to prove that the defendant recklessly and actually transmitted the infection to the complainant so cases should not proceed to trial even on the basis of a guilty plea unless there is scientific and/or medical and factual evidence.[5]

## 2.2 Transmission risk and recklessness

a. Condom use
It could be considered, according to the CPS and COPFS, a reasonable defence if someone had consistently used condoms even without disclosing their HIV status as this would be evidence that they were not 'reckless'. This has not been authoritatively tested in the courts, although in one

Scottish trial the jury were directed that they should not convict unless they were satisfied beyond reasonable doubt that the accused had not consistently used condoms.[12]

b. Use of antiretroviral treatment
The CPS and COPFS recognise that effective antiretroviral treatment significantly reduces the risk of HIV transmission and that depending on the facts of the case evidence that the defendant was taking effective antiretroviral treatment at the time of the alleged transmission may in some cases be used to demonstrate that they were not reckless.[4,5] It is the defendant's knowledge (usually after discussion with their HIV clinician) that they are unlikely to transmit HIV rather than the simple fact of having an undetectable viral load that is important in this situation. This has not been tested in the courts.

BHIVA and BASHH would support the use of antiretroviral treatment as a defence against recklessness where the estimated transmission risk for the type of sexual intercourse is low and when there is evidence of a) appropriate use (clinical history of adherence and undetectable viral load) and b) that the HIV positive individual has had regular STI screening as per BASHH guidelines.[13]

This position is based on the growing body of evidence that effective antiretroviral treatment considerably reduces the risk of sexual transmission of HIV;[14,15] this reduction is comparable to that seen with consistent condom use.[16] This is consistent with other HIV clinical practice/guidance in the UK where effective antiretroviral treatment reduces the risk of transmission to similar levels. For example, PEPSE guidelines do not recommend using PEPSE when the HIV positive contact has an undetectable viral load on antiretroviral therapy for all types of sexual intercourse, except anal sex where the negative partner is receptive.[17]

c. Post exposure prophylaxis after sexual exposure (PEPSE)
If, immediately following sexual intercourse, it is realised that a partner has been exposed to a risk of HIV transmission, then the patient should always be advised to disclose to enable the exposed individual to seek assessment from a health care professional on the need for PEPSE within 72 hours.[17] Should transmission occur in this situation, it is uncertain if disclosure in this context would be considered a defence to reckless transmission. However, given the CPS and COPFS guidance there is good reason to think that an individual who disclosed their HIV status in the event of condom breakage would not be regarded as "reckless".[4,5]

## 2.3 Evidence of source of infection

Scientific evidence alone is very unlikely to provide sufficient evidence that the defendant is the source of transmission; medical and factual evidence is also required.[4,5]

<u>Evidence based on the virus</u>

**a) Phylogenetic evidence**: The use of phylogenetic evidence (genetic analysis of similarities between the viruses of two or more people) to support a transmission event has been widely reviewed and specific advice has been issued.[18,19] The analysis is useful for epidemiological studies on entire populations, but suffers from important limitations when applied to the study of individual transmission events. It can be helpful in indicating that two infections are not related, but cannot conclusively establish that transmission has occurred in a particular direction between two individuals. Therefore phylogenetic analyses should not provide the basis for assuming transmission and should only be used in the context of other and stronger supporting evidence.

**b) Use of research/epidemiological data**: The UK HIV Drug Resistance Database is a national repository for genotypic resistance tests performed as part of routine clinical care. This resource was developed solely for the purpose of scientific research, with the objective of enabling more effective clinical interpretation of the results of these tests. By the end of 2008 over 51,000 test results had been received and curated. Most of these (around 90%) are in the form of viral gene sequences. The potential use of these sequences in medico-legal cases of HIV transmission has been extensively discussed by the study Steering Committee, which has agreed the following policy:

- Sequences will not be released, either at an individual or epidemiological level, for medico-legal cases, including as "control" data for assessing sequence variability.

Evidence based on temporal relationship to exposure

**c) STARHS/ RITA**: Serological testing algorithm for recent HIV seroconversion, or recent infection test algorithm, makes it possible to establish whether or not an infection is likely to have been acquired in the last 4-6 months.[20] It is used by the Health Protection Agency as routine public health monitoring of all new HIV diagnoses in the UK. It is also used in some routine diagnostic settings. It is common for results to be returned to the patients and health professionals have a duty to ensure that the findings are interpreted and discussed correctly. In particular, such testing only gives an approximate indication of a recent HIV infection and several factors affect the test performance, including advanced HIV disease, the use of ART and infection with subtypes other than B. Results must therefore be treated with caution and should not be relied upon as evidence of recent transmission for the purposes of a prosecution for reckless transmission of HIV.

## 3. Healthcare workers' duties to their patients and to others

In general, the actions of health care workers are informed by ethical considerations, which are in turn regulated by the appropriate professional governing bodies. In the case of doctors this is the General Medical Council.[21,22] Many of the concerns faced by doctors when dealing with issues relating to the subject of reckless transmission are addressed in the generic GMC guidance. However there may be specific legal duties and legal consequences of the actions of health care workers that need to be understood. In this section these ethical duties and legal considerations are reviewed. There are not always definitive answers and interpretations may differ between experts, both legal and ethical.

### 3.1 The duty of confidentiality

Confidential information is both legally and ethically protected from disclosure. In law, "a duty of confidence will arise whenever the party subject to the duty is in a situation where he knows or ought to know that the other person can reasonably expect his privacy to be respected".[23] A diagnosis of HIV or AIDS would ordinarily give rise to such a duty.

Confidentiality is not absolute. In particular, the public interest in maintaining confidentiality may sometimes be outweighed by another public interest favouring disclosure to a third party. Ultimately the public interest is decided by the courts. Furthermore, confidential medical information is not – in the UK at least – normally regarded as legally *privileged*, meaning that a healthcare worker cannot normally refuse to divulge it in court or in response to a court order.

**Legal duty 1:** A healthcare worker must maintain the confidentiality of patient information unless the patient has consented to disclosure or disclosure is necessary in the public interest. A failure to maintain confidentiality may give rise to legal liability.

### 3.2. The duty to advise properly

As well as maintaining confidentiality, a healthcare worker has an ethical duty both to the patient and third parties to properly advise his or her own patient with regard to protecting others from infection. Not doing so could clearly result in transmission of HIV to a third party leading to physical and psychological harm and the public health implications of increasing the number of HIV infected people. This is turn may be psychologically distressing to the patient knowing they have infected another individual.

Guidance on this point has been provided by the GMC in the following terms[24]

> You should explain to patients how they can protect others from infection, including the practical measures they can take to avoid transmission, and the importance of informing sexual contacts about the risk of transmission of sexually transmitted serious communicable diseases (paragraph 9)

A failure to advise patients on protecting others from infection could result in a legal liability to pay compensation (negligence).[25,26] Such liability has been imposed outside the UK and it is thought that courts in the UK would take a similar approach.

**Legal duty 2:** A healthcare worker must properly advise a patient on ways of protecting their sexual partners from infection. A failure to do this may give rise to legal liability if the patient's sexual partner becomes infected as a result. Liability may also arise where a healthcare worker negligently fails to diagnose the patient as having the infection.[27,28]

### 3.3. What if the healthcare worker believes that the patient is not following (or is unlikely to follow) the advice and putting sexual contacts at risk?

The matter is dealt with in the GMC's guidance on serious communicable diseases[24] as follows

> **Informing sexual contacts of patients with a serious communicable disease**
> You may disclose information to a known sexual contact of a patient with a sexually transmitted serious communicable disease if you have reason to think that they are at risk of infection and that the patient has not informed them and cannot be persuaded to do so. In such circumstances, you should tell the patient before you make the disclosure, if it is practicable and safe to do so. You must be prepared to justify a decision to disclose personal information without consent (paragraph 10)

In circumstances such as those noted in the GMC guidance, a decision to breach confidentiality, taken after careful consideration and consultation, would probably be considered to be in the public interest and therefore lawful. This must be carefully balanced with the doctor-patient relationship and the ongoing care of a person with HIV, as a breach of confidentiality will almost certainly end the relationship between any clinician and their patient, and may well cause the patient to disengage fully from any HIV services.

This does not, however, answer the question of whether a healthcare worker can be legally *required* to breach confidentiality and disclose a patient's HIV-positive status to a sexual contact. In law, the relevant question is whether the healthcare worker can be said to owe a 'duty of care' to that sexual contact,[29] so that they would be liable in damages if a breach of that duty (in this case, a failure to breach confidentiality where it was in the public interest to do so in order to protect that third party) caused the sexual contact to become HIV-positive.

Here, it is necessary to distinguish between three different categories of case. (See also Figure 1)

**(1) The sexual contact is also a patient of the healthcare worker**
Because healthcare workers owe duties of care to their own patients, it is considered likely that the courts would recognise a duty by a doctor to disclose the HIV diagnosis to the sexual contact in such a case. A failure to disclose might therefore be a breach of the duty owed to the sexual contact, resulting in liability in damages if the contact became HIV-positive as a result.

This situation has arisen where Genitourinary Medicine departments also provide HIV clinics, but is much more likely to occur in Primary Care services. General Practitioners should seek advice from the HIV consultant responsible for the HIV positive individual's care.

**(2) The sexual contact is not a patient of the healthcare worker**
Although it has been suggested by at least one academic writer that the courts should recognise a legal duty to third party disclosure in such circumstances,[29] the prevailing view is that no such legal duty exists.[26,30] It is thought, however, that disclosure would be lawful because of the public interest in protecting the contact from infection. In other words, it is thought that there is a *power* to disclose, but no *legal obligation* to do so.

Where there is a risk to a known third party there is a duty to consider whether the benefits to the third party of disclosing the information outweigh the public and the patient's interest in keeping the information confidential. If disclosure is judged to be in the public interest, the information should be disclosed promptly. If there is no ongoing risk of transmission of HIV then the justification for disclosure may be lost. For example where the patient has previously always used condoms with their partner and is not sexually active at present. However, disclosure in the context of anonymous contact tracing/ partner notification in Genitourinary medicine settings may still be appropriate. This is where the sexual contact of someone known to have a sexually transmitted illness, such as HIV, is contacted by a health professional in the clinic and asked to attend for sexual health testing. The identity of the person with the sexually transmitted illness may be withheld from contacts during this process.

**(3) There is no identified sexual contact**
Where a patient has indicated that he or she does not intend to either practise 'safer sex' or disclose their HIV-positive status to future (unidentified) sexual partners, it would appear that there can be no legal duty of third party disclosure by health care workers for the simple reason that there is no identifiable person to disclose to. Disclosure clearly cannot provide an effective means of preventing onward transmission of HIV in such cases, as it is unclear to whom such disclosure would be directed. One's ethical duty here centres on trying to prevent ongoing transmission through ongoing counselling and support of the patient around safer sex practices to facilitate behaviour change where possible.

**A caveat: the National Health Service (Venereal Disease) Regulations 1974**
Some doubt has arisen as to whether disclosure to sexual contacts may *ever* be permissible given the terms of the National Health Service (Venereal Disease) Regulations 1974, regulation 2 of which provides as follows:

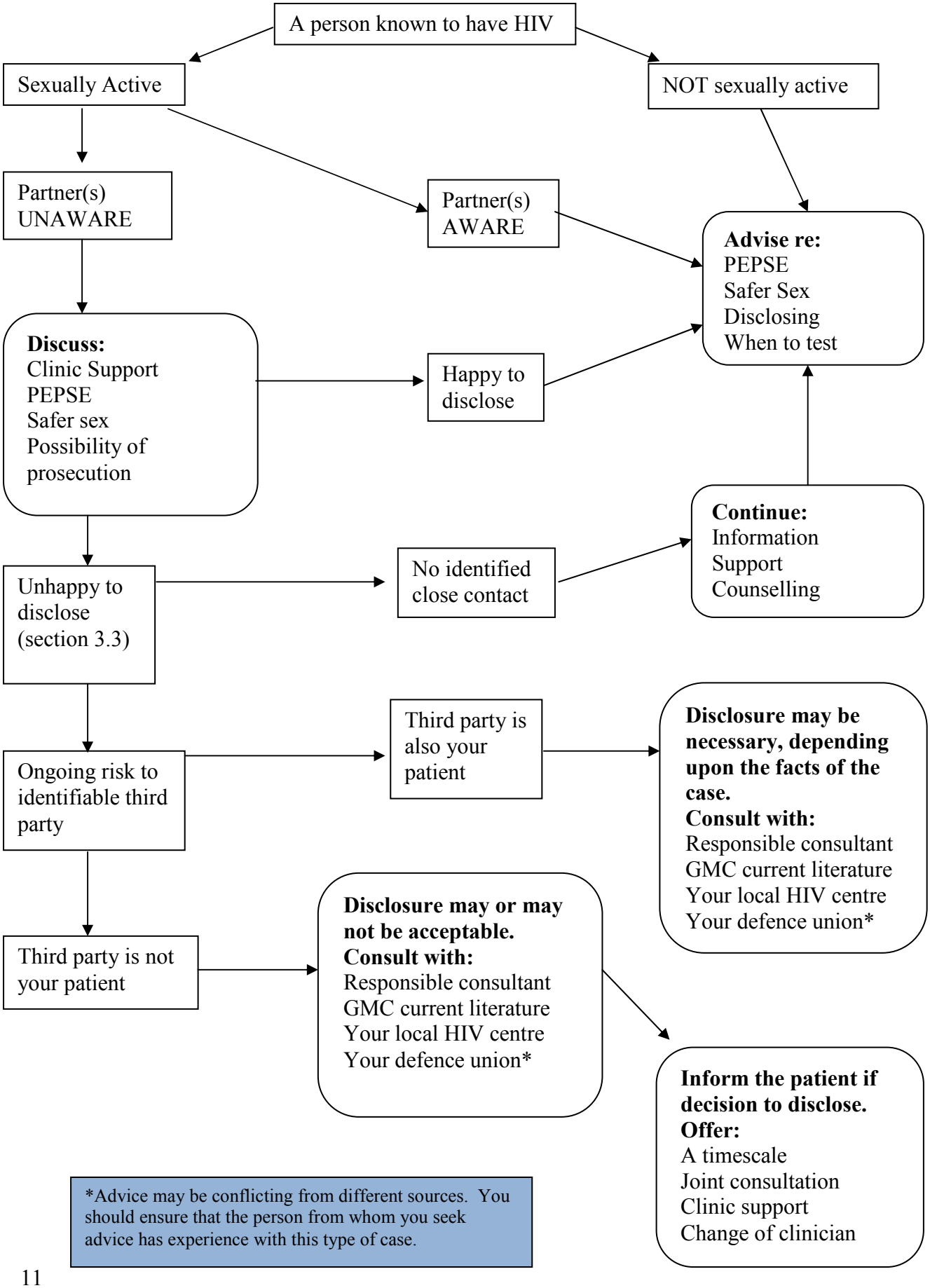
> Every Strategic Health Authority, NHS Trust, NHS foundation trust and Primary Care Trust shall take all necessary steps to secure that any information capable of identifying an individual obtained by officers of the Authority or Trust with respect to persons examined or treated for any sexually transmitted disease shall not be disclosed except –
>
> a. for the purpose of communicating that information to a medical practitioner, or to a person employed under the direction of a medical practitioner in connection with the treatment of persons suffering from such disease or the prevention of the spread thereof, and
> b. For the purpose of such treatment or prevention.

The effect of these regulations is not entirely clear and as they have never been subject of any court decision,[30] there have been a number of different interpretations as to their meaning. The GMC has recently made it clear that its view is that the regulations "do not preclude disclosure if it would otherwise be lawful at common law, for example with the patient's consent or in the public interest without consent".[24]

### 3.3.1 Public Health Law (Health Protection Regulations)

The Health and Social Care (England and Wales) Act 2008 and the Public Health Etc (Scotland) Act 2008 extended coercive powers to protect the public from infection or contamination. As a result magistrates now have powers to impose compulsory public health orders (Part 2A orders in England and Wales, part 4 in Scotland) on individuals. In England and Wales the DH has produced specific guidance on the Health Protection Regulations which includes sections on the unsuitability of the use of such powers for HIV infected individuals.[31,32] The equivalent Scottish guidance does not explicitly mention HIV. However, the Scottish legislation is more restrictively drafted, generally requiring a "significant risk to public health" for intervention rather than a risk to the health of individuals (as the English legislation does). This suggests that the powers will rarely if at all be available in respect of individuals with HIV.

**Figure 1:** Decision guiding algorithm: When a clinician might disclose HIV infection to a sexual partner



## 3.4. Disclosure to other healthcare professionals

The General Medical Council's guidance on confidentiality and serious communicable diseases[24] provides as follows:

> You should make sure information is readily available to patients explaining that personal information about them will be shared within the healthcare team, including administrative and other staff who support the provision of care, unless they object, and why this is necessary.
>
> If a patient refuses to allow you to inform someone outside the healthcare team of their infection status, you must respect their wishes unless you consider that failure to disclose the information will put healthcare workers or other patients at risk of infection. But such situations are likely to be very rare, not least because of the use of universal precautions to protect healthcare workers and patients, particularly during exposure-prone procedures. (paragraphs 7 and 8)

The legal principles here are, in principle, little different from those involved with regard to disclosure to sexual contacts. Because of the public interest in preventing the onward spread of infection, disclosure may be a justified breach of confidentiality where it is necessary for this purpose. Because healthcare workers owe a duty of care not to put co-workers at risk, a failure to disclose might even give rise to legal liability where it was necessary to prevent another worker from a serious risk of infection. A purely hypothetical risk should not, however, be regarded as permitting disclosure without consent within the terms of the GMC's guidance.

However, such cases are likely to arise only very exceptionally indeed. In routine practice the use of **standard precautions** (previously universal precautions) will be enough to protect health care workers from infection, thereby making disclosure unnecessary. Furthermore, it is each individual health care worker's personal responsibility to use standard precautions at all times for their own protection from blood borne infections, many of which are undiagnosed.

### 3.4.1. What if the risk to the sexual contact has become apparent as a result of health care professionals sharing information?

Where information has been legitimately shared between health care professionals as part of proper patient care, and one doctor has become aware of a risk to a sexual contact, a breach of confidentiality may be permissible (or required) in the same way as described in 3.3 above. Where information has been improperly shared, this creates a difficult situation. Confidentiality clearly still applies to information which has been improperly passed on, but such sharing of information may result in a situation where (a) there is a duty to disclose to a sexual contact and (b) this will or may make apparent the earlier breach of confidentiality. Such situations should be avoided by only sharing information about patients where this is in accordance with the GMC guidelines. However, if information is shared improperly and does highlight a risk, then this risk will need to be addressed and a further breach of confidentiality may ultimately be permissible (see section 3.3 and figure 1). Those who have shared the information must seek a way to share the information properly (such as a GP communicating with a hospital clinician) and to engage with the person living with HIV, emphasising a need for safer sex, disclosure etc (see sections 4.2.1 and 4.2.2). Advice from a medico-legal defence union would be appropriate. A breach of confidentiality that can bring such a risk to light should trigger reflection on information sharing by those involved.

## 3.5 Disclosing information to the police.

If a patient has become HIV-positive as a result of potentially criminal actions by a third party, it is that patient's choice whether or not to bring it to the attention of the police. For a clinician to do so without that patient's consent is not legally required, and would be a breach of the patient's right to confidentiality. It is for the patient to take that decision and to initiate it with appropriate legal guidance, **NOT** the health care provider. It is also inappropriate for doctors to place any pressure on an HIV positive patient to take legal action against a third party (or indeed not to take legal action).

People living with HIV who wish to take such action are likely to have particular need for specialist advice and support (see 4.2.3 ). There are limited circumstances in which doctors have an ethical duty to report criminal activity. GMC guidance recognises that, in rare instances, there may be a need for third party disclosure in order to halt ongoing criminal activity or prevent criminal acts that might take place in the future.[22]

> Such a situation might arise, for example, when a disclosure would be likely to assist in the prevention, detection or prosecution of serious crime, especially crimes against the person. When victims of violence refuse police assistance, disclosure may still be justified if others remain at risk, for example, from someone who is prepared to use weapons, or from domestic violence when children or others may be at risk. (paragraph 54)

However BHIVA and BASHH do not believe that this should apply with regards to reckless transmission of HIV. In the event of a complaint being taken to court the complainant's sexual history is likely to be examined with as much rigour as that of the defendant, so it is essential that the decision to take a complaint to the police should rest exclusively with the individual. It is important to remember that disclosure to the police is distinct from disclosure to a known sexual partner who is being put at risk.

It should also be remembered that in England and Wales there is no crime of recklessly exposing someone to the risk of HIV transmission and that in Scotland that the law is unlikely to be used in this way. The clinician is not in a position to know that the patient is actually going to transmit HIV, or ordinarily to know anything of the sexual history or HIV status of any sexual partners. Whilst concern and appropriate interventions are necessary for anyone putting others at ongoing risk of infection, it is very doubtful whether such circumstances would usually be sufficient to justify the breach of confidentiality involved in reporting someone to the police.

**Requests for information from police (see section 4.2.4)**
Health care professionals have no duty to answer questions that the police ask about their patients, unless the request is sanctioned by a court order. The paper and electronic medical records are owned by the NHS Trust (hospital) or Secretary of State (GP records), and cannot be released without permission of the NHS Trust (acute or primary care) within which they are held. Additionally medical records or information held within them must not be disclosed unless either a) the patient's consent, to the satisfaction of the consultant or general practitioner in charge of their care, is given or b) a court order has been issued. A police request in its own right makes no obligation to disclose. Where there is no consent from the patient the responsible clinician (HIV consultant or GP) should be informed and indicate to the police that a court order will be required. It would be advisable for the responsible clinician to keep the Caldicott Guardian and/or the local clinical ethics committee or Trust's legal team informed.

If records are to be disclosed to the police because the patient consents or because a court order has been made, then care must be taken to remove any third party identifying information.

**Table 1: Guidance for disclosure to legal agencies:**

| | COURT ORDER | POLICE REQUEST |
|---|---|---|
| **Initial Request** | Information specified must always be disclosed after following local NHS guidelines. | This must be accompanied by consent. The consultant/ GP must go to reasonable lengths to discuss with the patient to ensure this consent is valid. There is no obligation to disclose information. |
| **Patient consent for disclosure** | Patient's consent is not required, however it would be best practice to inform the patient the request has been made. | Patient consent must be verified by speaking directly to the patient. |
| **Information sharing** | All local NHS protocols and procedures for information sharing must be satisfied before disclosing any information, even for a court order. Third party information must be removed, unless explicitly asked for in a court order. | |

### 3.6. Disclosing information in court

Although medical information is confidential, it is not legally privileged. This means that if a health care professional is required to testify in court under oath all information must be disclosed. Failure to give such information would be a contempt of court

# 4. Recommendations for Clinical Practice

## 4.1 The ethical decision making process

When faced with an ethical dilemma in medicine the process of decision-making needs to be of the highest integrity and must be clearly documented. Clearly one must operate within the law and follow professional ethical guidance as from the GMC. As highlighted in section 3, there are areas where the law remains uncertain and no one case is exactly the same as another, so any guidance will always be incomplete. It is important therefore that all ethical decisions are made on a case by case basis, identifying and balancing all relevant harms and benefits. In considering a course of action one should ask, is this a reasonable action to take and how is this action justified? For example, when considering disclosure of HIV status to a third party, if the justification is to prevent ongoing risk of HIV transmission, then there must be continued risk of HIV transmission, such as unprotected sexual intercourse for this justification to hold. See Figure 1.

Normally, the overall responsibility for the patient rests with the clinician whose name is recorded as caring for a patient (GP or Consultant dependant on the setting). However, care is delivered within a multidisciplinary team and decision-making should involve all relevant team members. Clear lines of responsibility and accountability with mechanisms for discussion amongst team members should exist in all clinical services with responsibility for the care of people with HIV infection. General Practitioners and community health care professionals are advised to contact the consultant responsible for the HIV care of the patient to enable joint decision making. Additionally, mechanisms must be in place for the appropriate education and support of health care professionals in this rapidly evolving area. If unavailable locally such mechanisms should be available within existing managed clinical networks. All healthcare professionals working with people with HIV must be familiar with the ways in which data is stored and confidentiality of medical information is maintained within their service and be able to explain this to patients as required. If a consultant finds her/himself in the unusual position of being responsible for the care of two patients with HIV, who are complainant and defendant in a prosecution for reckless transmission, there may be a conflict of interest which will be detrimental to the therapeutic relationship and it may be appropriate to transfer the care of one patient to a consultant colleague.

## 4.2 The roles and responsibilities of health care professionals

The particular roles of health care professionals caring for individuals infected with HIV are:

- To advise patients with HIV appropriately about HIV infection and the implications for themselves and others.
- To support patients with HIV appropriately.
- To ensure confidentiality of medical information in line with GMC guidance
- To keep meticulous records of all consultations, including advice given over the telephone, as well as copies of e-mail correspondence with patients, in line with Royal College of Physicians' and General Medical Council guidance.[21,33]

HIV specialist services are best placed to provide the most up to date advice and support to people with HIV. These roles could also be carried out by health care professionals outside of HIV specialist services provided they have the relevant knowledge and experience. Where their knowledge and experience are limited advice should be sought from the HIV service providing care to that individual patient or the local HIV service/network.

### 4.2.1. Advice that should be provided by the clinical team to all patients diagnosed with HIV infection

**Above all, advice given to patients must be thoroughly documented and dated to be able to justify it in the context of the state of knowledge contemporaneous with the advice.**

**It is suggested that at the time of the writing, to help prevent transmission of HIV to sexual partners and to avoid prosecution for 'reckless' HIV transmission people with HIV should do at least one of the following:**

- **Use a male or female condom fitted correctly along with water-based lubricant. Individuals doing this are unlikely to be seen as reckless for legal purposes. In the event of a condom split, it is advisable to disclose HIV status in order to support the partner's decision whether or not to obtain post-exposure prophylaxis (PEPSE), which should be taken within 72 hours. The need for PEPSE will depend upon the type of sexual activity and the HIV viral load. An assessment of the risk should be undertaken by a clinician according to the BASHH PEPSE guidelines.**

- **Adhere to effective (suppressed viral load) antiretroviral medication. There is growing evidence of extremely low/minimal risk of transmission when plasma HIV is fully suppressed with the use of antiretroviral medication. In some situations an undetectable viral load can afford protection equivalent to or greater than that of condoms. A person with HIV is unlikely to be seen as reckless when relying on a suppressed viral load instead of condom use if they have been counselled accordingly by an HIV clinician or similar medical authority. It is recommended that this discussion is documented in the patient's medical records.**

**In addition people with HIV should be advised that disclosure of HIV positive status to a partner before sex is important to support informed agreement around risk and safer sex behaviours. To avoid successful prosecution an individual who is not taking effective antiretroviral medication and does not use a condom must disclose their HIV status to sexual partners before sex takes place.**

a. Giving proper, up to date, relevant advice in a way that people with HIV can fully understand (e.g. taking into account language, cultural sensitivities, educational level, literacy and other factors) is critical. All advice given by members of the multidisciplinary team to people living with HIV must be consistent and care should be taken to avoid any conflicting messages. Clinical teams may wish to review the information given to patients to ensure consistency within the team. Any advice should be provided in both verbal and written forms in appropriate language, ensuring the patient understands.

b. Giving advice is an ongoing process and clinicians should discuss sexual behaviour and assess sexual and reproductive health needs regularly with patients according to relevant BASHH guidelines,[13] ensuring that advice given is appropriate to the patient's circumstances and needs.

c. All people living with HIV should receive Information from their clinical team regarding the nature of HIV infection, its routes of transmission, and the ways in which HIV transmission can be reduced. In particular details about the correct use of condoms to prevent transmission should be provided, together with information about safer sexual activities and their relative risks. Such information is not only important for the well being of third parties but also for the person living with HIV for whom risks of transmission to someone else may be personally very distressing.

d. The link between plasma viral load and sexual transmission of HIV should be discussed (refer to 2.2. [b]).

e. Information should be given that HIV infection is not outwardly visible and no assumptions about the HIV status of sexual partners should be made without specific discussion.

f. People living with HIV should be advised that sharing information about an HIV diagnosis with sexual partners provides the best way of allowing informed decision making about sexual behaviour for all the parties concerned.

g. People living with HIV should be advised about the availability and utility of post-exposure prophylaxis following unprotected sexual intercourse or a condom split (PEPSE). This should be documented. This will mean that the patient may have to disclose the HIV infection risk at some stage, possibly post facto. Disclosure to enable a partner to seek PEPSE and thus reduce the risk of transmission of HIV is the appropriate and responsible course of action in this situation. In sero-discordant couples, where both partners have been counselled it may be appropriate to give a starter pack of PEPSE to keep at home in case of a transmission-risk episode.

i. People with HIV should be advised that that there have been successful prosecutions when reckless transmission of HIV has been proven to have taken place. Care needs to be taken in the way that this information is imparted to patients. It is crucial for an ongoing therapeutic relationship that it is perceived neither as a threat nor as a means whereby clinical staff impose their own beliefs on their patients. As stated above, prosecution for transmission is possible when the HIV positive partner has not disclosed his/her HIV infection to the sexual partner before having unprotected intercourse.

j. People with HIV need to recognise that the best clinical attention will be given by healthcare workers who are aware of the patients' complete medical history. This requires appropriate sharing of medical information with other healthcare professionals involved in the patients care.

### 4.2.2. Support by clinical staff for People with HIV

a. In a GUM clinic setting health advisors will normally start discussion about and support for the process of disclosure to current sexual partners after diagnosis. Anyone needing additional support should be given further health advisor appointments as necessary. It is however incumbent upon all members of the team to provide support and advice as required or to refer appropriately.

b. Clinical staff involved in the care of people with HIV need to acknowledge that disclosing HIV infection to partners can be very difficult and frequently fraught with anxieties about the perceived outcome,[34] and potential stigma and discrimination.[35] Patients should be helped to understand that they will need to come to terms with their diagnosis as part of the process of disclosure. It is important that individuals are given enough time and appropriate support according to their individual needs.

c. Disclosure should be seen as a process rather than an event and patients given support throughout that process. There should be discussion and agreement about an appropriate time frame for disclosure wherever possible. It should however be borne in mind that this is not the approach usually taken by the courts, where disclosure is seen as necessary immediately if a possible charge of reckless transmission is to be avoided.

d. The clinical team should give patients information about, and where necessary direct referral to, additional sources of support, peer groups and voluntary sector agencies. Appropriate leaflets and the details of sources of specialist information should be available in all clinical settings in appropriate languages and formats

e. In circumstances of non-disclosure, this should be discussed sensitively on an individual basis to establish barriers that exist and provide support in addressing these.

f. It is important to distinguish between previous risk and ongoing risk. When there has been a previous risk but no ongoing risk there may be no need to disclose HIV status to the partner as anonymous partner notification may be sufficient to warn the partner that they may have been at risk.

f. General practitioners and community health care professionals should discuss such cases with the consultant responsible for the HIV care of the individual patient or the local HIV service if the patient is not currently under follow up. Any disclosure decisions must involve the HIV consultant.

g. It is important that the issues of disclosure are revisited and as circumstances change appropriate advice and support are made available. If a complex case of continued non-disclosure arises, it will be important for the named consultant and members of the MDT to make disclosure decisions based on current GMC good practice and relevant to the current legal situation. See Figure 1.

h. In managing cases of continued non-disclosure clinicians may seek advice from a number of possible sources including the local HIV network, HIV clinicians, defence unions, legal teams and the GMC. As this area is evolving, the solutions to a single scenario may be contradictory from different sources. It is of paramount importance to ensure that the person, rather than agency, from whom you obtain advice has experience working with this particular type of case.

h. It is important to provide information on the data that are kept about patients, and the duties of confidentiality of health care professionals in protecting such data, in order to ensure that the clinical setting is perceived as a safe arena for full and uninhibited discussion of the situation facing the patient.

### 4.2.3. Advice and support for patients involved in potential cases of reckless HIV transmission

a. Individuals who believe they may be the injured party in a case of reckless transmission and those accused of recklessly transmitting HIV must be given all the advice appropriate to any person living with HIV, and offered PEPSE if appropriate.[17]

b. Some patients may express a wish to bring criminal charges against a sexual partner. In this situation it is important that the patient is given time to discuss the implications of this approach with an appropriately experienced advisor. There is a leaflet for people with HIV from NAT/THT on prosecutions which should be provided and the person should be strongly encouraged to speak to THT Direct as soon as possible. Support and advice may also be provided by their local HIV support organisation.

c. Ultimately it is for the patient to decide if they wish to bring the issue to the attention of the police, and not the role of the health care worker.

d. In addition both the accused and complainant will need specialist legal advice and peer support. Appendix two has a directory of further sources of information and support to which they may be signposted. In particular, THT Direct is staffed by workers trained specifically in these issues and onward referral for support would prove useful. There have been a number of cases where people with HIV accused of criminal HIV transmission have been very poorly represented and advised during criminal proceedings. Clinic staff should strongly encourage anyone subject to police investigation or prosecution to ring THT Direct as soon as possible to ensure they receive appropriate legal support.

### 4.2.4. Requests for Information by the Police (See also section 3.5 and table 1)

Information may be requested as part of an investigation of alleged reckless HIV transmission. This may pertain to claimant, defendant or sexual contact(s) of a claimant or defendant; the same process should be followed in each case. It should be borne in mind that if there is enough factual evidence of reckless transmission the defendant can be charged without scientific and/or medical evidence. Scientific and medical evidence can then be requested by a court order as necessary.

All clinical services should develop local guidance about actions to be taken in the event of police enquires. These should include the following:

Any requests from the police for information about patients should, in the first instance, be directed to the consultant or General Practitioner (GP) in charge of the patient's case. If information is requested from the GP regarding a case of alleged reckless transmission of HIV then the GP should discuss the

case with the patient's HIV consultant. Depending upon the information requested it may be more appropriate for the consultant rather than the GP to provide a (medical) report.

The consultant or GP must be absolutely satisfied that the patient's consent is valid, and every attempt should be made to discuss this in person with the patient. If the patient has a legal representative through whom communications can be made, then they should be part of this process.

Local information sharing protocols and information governance procedures must be followed and Trust or Practice level management and legal advisers should be informed of any such request as necessary.

Where there is no consent from the patient the responsible clinician (HIV consultant or GP) should be informed and indicate to the police that a court order will be required. It would be advisable for the responsible clinician to keep the Caldicott Guardian and/or the local clinical ethics committee/Trust legal team informed.

When releasing records, attention must be paid to the fact that patient records may hold personal details of third parties e.g. contact tracing details in Genitourinary Medicine. These must be removed before releasing notes to external agencies.

With regards to tracing other (sexual) contacts of claimant or defendant identified as part of an ongoing investigation then it is best if contact tracing is carried out by local sexual health services as opposed to the police. Therefore police may also request that a person be contacted with a request that they have an HIV test. This may be to identify other people possibly infected by the accused, or other people who may possibly have infected the complainant.[36]
In approaching individuals either requesting consent for information to be disclosed, or with a request that they be tested for HIV since there is a possibility they may be at risk, it is important to state clearly that the approach has been prompted by a police investigation into a third party. Although the police may have an interest in the results of such testing, information on individuals must not be disclosed to the police without their consent or a court order.

## 5. Reckless transmission and Vulnerable Groups.

Accusations involving vulnerable people are particularly complex and difficult to manage both in terms of the law and in providing care. It is extremely important to seek advice and guidance in these situations. Issues of consent will be of primary importance in relation to both the claimant and the defendant. The English code for Crown Prosecutors[37] makes it clear that vulnerability is a factor relevant to prosecution; however in Scotland this is specifically highlighted in relation to consent in the COPFS prosecution policy regarding sexual transmission of infection[4] as a factor in deciding on whether a prosecution will take place. Given the difference in Scottish law related to consent there may be a lower threshold, in terms of the claimant's vulnerability, to prosecute reckless transmission.

#### 5.1.1 The Under- 18s

Young people under the age of 18 years old are in law children, those under 16 years cannot legally have sexual intercourse, and those under 13 years are deemed unable to consent to any sexual activity. Adults usually assume younger adolescents are not sexually active. In reality at least 25% have had sexual intercourse by their 16th birthday and most do not use condoms at first sexual intercourse.

The onus is on healthcare professionals and the voluntary sector to ensure that the young person realises the risks of unprotected sex both to themselves and others. Information given to HIV positive adolescents must be the same as that given to adults on this issue, including criminal liability. The way the information is given must be tailored to the physical, emotional and intellectual maturity of the young person. The information will need to be revisited but using different terms and language as they mature and their understanding increases. In order to be effective, information on use of condoms and reckless transmission needs to be given to young people before first sexual activity. If information is not given and transmission does occur the health care provider could be said to have failed in their ethical duty to the patient and potentially be held legally responsible (see section 3.2 on duty to properly advise). This could also apply if the young person has not been told they are HIV positive by parents/carers or healthcare providers, for whatever reason. Although there would be no criminal liability, there is a potential for civil charges (negligence) to be brought. This has not been tested in courts in the UK, however, there is precedent for this in the US where a doctor failed to inform a child (or her parents) that she had received a contaminated blood transfusion; she subsequently transmitted HIV to her boyfriend.[38]

Reckless transmission does not occur if the sex partner is competent, aware of the diagnosis and chooses not to use condoms. However in the case of adolescents their partner is likely to be of a similar age and may not be *competent* and have sufficient understanding to agree to non-use of condoms, even if disclosure of HIV positive status had been made.

### 5.1.2 Recommendations in the event of an accusation against, or by, someone younger than 18

a. Such cases should be managed within the local trust frameworks for assessing risks of sexual exploitation against younger people, and according to nationally developed protocols, such as BASHH guidelines for management of STIs in children and young people.[39]

b. The competency of both the accused and accuser to consent to sexual intercourse and therefore accept the risk of transmission should be assessed.

c. Should someone below 18 be subject to investigation, the Youth Offending Service can provide invaluable support for protecting their individual needs. It is worth bearing in mind that Youth Offending Services unfamiliar with HIV may need advice themselves.

d. Any interview which is legal or has legal implications, should take place in the presence of an appropriate adult (this need not be a parent or legal guardian, depending on the young person's choice).

e. Specialist legal advice and representation is important and the young person and/or their carers should be directed to THT direct.

f. Confidentiality of the young person has many potential chances of being accidentally breached, given that multi-agency care is sometimes necessary. It will be vital not to breach confidentiality unless absolutely required.

**5.2 Individuals with Learning Difficulties**

Those with learning difficulties will need extra support whether they are the accuser or the accused. If someone or their carer wishes to bring a charge, then services such as, hospital/ community special needs teams, adult safeguarding teams and practitioners skilled in determining competency (such as psychologists or psychiatrists) need to be involved early on in any inquiry. In addition, with the patient's/ carer's permission, any key workers or contact points already known by the accused should be involved. For those who are accused, it must be borne in mind that the stress of such an inquiry may be magnified by their particular difficulty. If there is a key worker available, then they would be a good locus for co-ordination of emotional/psychological support. Again, it will be necessary to have competency assessed as this will be key to whether a prosecutable activity has taken place.

## Appendix: Further Sources of Information

### Official Guidance:

**Crown Prosecution Service: Intentional or reckless sexual transmission of infection guidance**
Accessed 29/09/11
http://www.cps.gov.uk/legal/h_to_k/intentional_or_reckless_sexual_transmission_of_infection_guidance/

**Crown Office and Procurator Fiscal Service: Sexual Transmission or Exposure to Infection – Prosecution Policy 2012**. Accessed 15/09/2012
http://www.crownoffice.gov.uk/Publications/2012/05/Sexual-Transmission-or-Exposure-Infection-Prosecution-Policy

**ACPO investigation guidance related to the criminal transmission of HIV**
http://www.nat.org.uk/Our-thinking/Law-stigma-and-discrimination/Police-investigations.aspx
Accessed 12/10/2011

### General Resources:

**HIV and the criminal Law**. Edited by Edwin J Bernard. NAM publications. Accessed10/10/2010
http://www.aidsmap.com/law/

**UNAIDS Policy Brief: Criminalization of HIV**
Accessed online 29/09/11
http://data.unaids.org/pub/BaseDocument/2008/20080731_jc1513_policy_criminalization_en.pdf

**THT "Policing Transmission': A review of police handling of criminal investigations relating to transmission of HIV in England & Wales, 2005-2008.**
Accessed online 29/09/11
http://www.tht.org.uk/informationresources/publications/policyreports/policingtransmission950.pdf

**NAT policy webpages on Criminal Prosecutions and Police Investigations**
http://www.nat.org.uk/Our-thinking/Law-stigma-and-discrimination/Criminal-prosecutions.aspx
http://www.nat.org.uk/Our-thinking/Law-stigma-and-discrimination/Police-investigations.aspx

**THT**
Accessed online 29/09/11
http://www.myhiv.org.uk/Telling-people/Law

**NAT**
Accessed online 29/09/11
http://www.nat.org.uk/Living-with-HIV/Useful-information/Criminal-prosecutions.aspx

**NAT/THT joint leaflet: Guidance on Criminal Prosecutions for people living with HIV. May 2010**
Accessed online 29/09/11
http://www.nat.org.uk/Media%20library/Files/PDF%20documents/2009/Feb/NAT-THT%20Guide%20re%20Prosecutions%20May%202009%20Single%20Pages.pdf

**NAT leaflet: The Police Investigation of HIV Transmission. May 2011**
Accessed online 12/10/11
http://www.nat.org.uk/Media%20library/Files/Policy/2011/Police%20Investigation%20of%20HIV%20Transmission%20ACPO%20leaflet%202011-3.pdf

Weait M *Intimacy and responsibility: The criminalisation of HIV transmission.* Oxford, Routledge-Cavendish. 2007

## Relevant Organisations:

**British HIV Association**
BHIVA Secretariat:
1 Mountview Court, 310 Friern Barnet Lane, London N20 0LD
Telephone: +44 (0)20 8369 5380
Facsimile: +44 (0)20 8446 9194
Email: bhiva@bhiva.org
Web: http://www.bhiva.org

**British Association for Sexual Health and HIV**
BASHH Secretariat:
Royal Society of Medicine, 1 Wimpole Street, London W1G 0AE
Telephone: +44 (0)20 7290 2968
Fax: +44 (0)20 7290 2989
Email: bashh@rsm.ac.uk
Web: http://www.bashh.org/

**National AIDS Trust**
Telephone: +44 (0)20 7814 6767
After hours number: +44 (0)20 7814 6767 (5pm-9am)
Fax: +44 (0)20 7216 0111
E-mail: info@nat.org.uk
Web: http://www.nat.org.uk/contact/index.cfm

**The Terrence Higgins Trust**
Terrence Higgins Trust Direct
Telephone: 0845 12 21 200
Web: http://www.tht.org.uk

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