HIV transmission, the law and the work of the clinical team.
A briefing paper.

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1. Introduction

This paper has been written to provide information and guidance to health care professionals in their work. Recent legal cases concerning HIV transmission have raised complex questions for both clinicians and service users about rights, responsibilities and legal obligations to disclose information to others. Clinicians working with people living with HIV are faced with situations that can bring various social values, including civil liberties, public health concerns, confidentiality, autonomy, and discrimination, into conflict. Although established generic ethical and professional principles continue to apply, certain features of the HIV epidemic have required special consideration. For an effective therapeutic relationship to be established and maintained people living with HIV and their clinical carers must be able to discuss any relevant matter openly. An underlying principle in the provision of clinical care for people with HIV is the need for a secure and confidential environment in which extremely sensitive matters can be frankly and fully discussed. The importance of ensuring that full trust is maintained by people with HIV in their clinical services in the light of the introduction of the criminal law into the HIV arena is fundamental, not only for the health of people living with HIV but also for people who may wish to seek information or testing and thus for the wider public health.

This paper focuses on the responsibilities and duties of health care staff in the knowledge that other sources of information on this matter exist for other audiences, including people living with HIV (see appendices for references and for additional sources of information.).

2. Background

As of March 2006, there have been seven criminal convictions for the reckless transmission of HIV in the UK, one in Scotland and six in England and Wales. All have involved the transmission of HIV through heterosexual contact. English cases have been brought under the Offences against the Person Act of 1861, Section 20 (recklessly inflicting grievous bodily harm). In the Scottish case, a Scots-specific offence of “reckless injury” was used. Much of the legal discussion in these cases has focussed on the issue of disclosure (or lack of disclosure) of HIV status to sexual partners and the definitions of what might constitute recklessness. After representations from a number of HIV organisations, the Crown Prosecution Service is currently holding a consultation in advance of drawing up guidelines for prosecution in future. This paper is written pending further information from that process.

In 1998, the Home Office issued a White Paper (Violence: reforming the Offences Against the Person Act 1861) following consultations. Its proposals included a new offence, not specific to HIV, of intentional transmission of a serious disease (akin to Section18 of the 1861 Act) but not of reckless...
transmission (in line with Section 20 of the 1861 Act). The Home Office accepted that the latter should not be criminalised, on clear public health grounds, following submissions from a number of concerned organisations including Terrence Higgins Trust and the National AIDS Trust. This continued to be seen as the official Home Office position, but the White Paper remained a proposal only, and was never enacted in law.

In 2003-4, the Crown Prosecution Service began to pursue a number of cases of people charged with either intentional or reckless transmission. Of the two cases originally charged with intentional transmission, both were subsequently reduced to reckless transmission, a charge that is less difficult to prove. Of six prosecutions in England and Wales five have ended in substantial prison sentences (between two and ten years). In one case, a man was charged prior to HIV testing, apparently after being informed by his wife that he was deemed by her to be at “high risk” and should undertake an HIV test, a suggestion that he did not take up. He was nevertheless convicted of reckless transmission. At the time of writing three of the six convictions in England and Wales have been of African men, leading to particular anxieties in UK African communities (AHPN 2005). In at least two of these cases an additional recommendation has been made for deportation at the end of sentence. One of the men convicted has already died prior to the end of his three-year sentence.

The prosecutions to date have been accompanied by often provocative and sometimes poorly informed media coverage, with the use of terminology both in the press and the courts (e.g. HIV attacker, HIV Predator, HIV Assassin and HIV Refugee), which may have contributed to misinformation about HIV and its transmission. Stigma surrounding HIV infection and people living with HIV/AIDS has been accentuated by their portrayal as potential criminals and as a threat to public health. Given the stigma that still surrounds HIV and the persistence of HIV-related discrimination, there is anxiety that criminal sanctions may be disproportionately directed at those who are socially, culturally and/or economically marginalized. A recent survey by the UK coalition of people living with HIV found that over 80% believed that prosecution would serve to increase the stigma associated with HIV infection (UKC 2005). There is real concern that use of the criminal justice system in HIV transmission may contribute to the further marginalization of all people living with HIV infection with little regard for their actual behaviors or circumstances. The authors believe that the law should complement public health objectives rather than work against them.

The Crown Prosecution Service (CPS) has set up a working group to review the issue of reckless transmission of HIV and other sexually transmitted infections. It is the CPS, which on reviewing the background to the case and the strength of current evidence and knowledge will make the decision on whether or not to bring a case to court. The CPS has taken advice from a range of health care professionals, academic experts and HIV voluntary sector organisations on this matter and is due to report during 2006 (contact Brian Horne and Anne Murphy).

Studies show that many people living with HIV/AIDS experience discrimination in the healthcare setting (Sigma Research 2004, Terrence Higgins Trust 2001). Stigma and discrimination compromise quality care for those who are infected (or suspected of being infected), discourages people in need from accessing services, and undermines HIV prevention efforts. Stigma and discrimination impact on the uptake of voluntary counselling and testing (VCT) and programs for the prevention of mother-to-child HIV transmission. Prioritising the rights and dignity of people who have been diagnosed or are at risk of HIV infection creates the conditions necessary for successful prevention, treatment and care. In many international policy contexts, an integrated approach to addressing HIV prevention, care and treatment that is founded on human rights and dignity has been advocated. This is clearly embodied in HIV/AIDS and Human Rights international Guidelines (United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS 1998) and also in the Declaration of Commitment on HIV/AIDS (United Nations 2001).

Disincentives to disclosure of HIV status are many and varied and include fears of rejection and abandonment, discriminating treatment such as eviction or termination of employment, retribution, violence, and other forms of abuse. Most of these possible outcomes are based on the social stigma that is widely acknowledged to be associated with an HIV diagnosis. Already marginalized and disempowered individuals (for example members of migrant and ethnic minority communities) may be particularly reluctant to risk these adverse reactions. The routes of transmission and methods for prevention of HIV are well established. It may be argued that disclosure of HIV status is neither necessary nor sufficient to ensure that safer sex is consistently practiced. However lack of disclosure associated with onward transmission has been an important determinant in the successful convictions for reckless transmission.

The authors do not believe that invoking criminal sanctions will in any way ameliorate the difficult decisions to be made relating to disclosure. There is concern that in some instances the risk of alienation and harm resulting from criminal sanctions may serve to exacerbate such difficulties. Although the evidence base on the impact of prosecution for reckless transmission on the uptake of HIV testing remains unproven, disquiet has been expressed that fears surrounding disclosure may act as a disincentive to the HIV testing, which will undermine current strategic initiatives to improve HIV treatment and care and reduce onward transmission. However based on recent events it is clear that people living with HIV in the UK must be aware of the risk of legal action if they do not disclose their status to sexual partners and there is onward transmission of HIV. The consistent use of condoms (without disclosure) may possibly provide a successful defense against the charge of reckless transmission. However this has not been clarified by the Court of Appeal and the CPS have yet to determine whether evidence of consistent and appropriate condom use will be treated as a
relevant factor in deciding whether or not to prosecute. Health care providers have a responsibility to ensure that this information is appropriately given to patients¹ (See section on clinical practice below).

4. 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 (GMC) (GMC 2001, 2004). 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.

4.1 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”.² A diagnosis of HIV or AIDS would ordinarily give rise to such a duty.

In practice, although the duty of confidentiality might be enforced by resort to the courts, litigation on such matters is relatively rare. Complaints to a regulatory body such as the GMC are a more likely consequence of a breach of confidence. 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 parties, a point, which is discussed further below. 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.

² Campbell v MGN Ltd [2004] 2 Weekly Law Reports 1232 (House of Lords), per Lord Hope of Craighead at para 85.
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.

4.2. The duty to properly advise

As well as maintaining confidentiality, a healthcare worker must properly advise his or her own patient. The crucial requirements are set out in the GMC’s guidance on serious communicable diseases:

If you diagnose a patient as having a serious communicable disease, you should explain to the patient:

a. The nature of the disease and its medical, social and occupational implications, as appropriate.
b. Ways of protecting others from infection.
c. The importance to effective care of giving the professionals who will be providing care information which they need to know about the patient's disease or condition. In particular you must make sure the patient understands that general practitioners cannot provide adequate clinical management and care without knowledge of their patients' conditions.

It is normally well understood that a failure to comply with requirement (a) might give rise to legal liability if the patient’s health were to suffer as a result. What is perhaps not always recognised is that a failure to comply with requirement (b) might also result in liability.

If a patient who has been (or should have been) diagnosed as being HIV-positive is improperly advised on this point (or not advised at all), and a sexual partner becomes HIV-positive as a result, the healthcare worker is potentially liable, (i.e. for financial damages, possibly via the employing Trust) to the sexual partner – even though that person is not their patient. The same principle would apply in respect of other serious STIs, such as Hepatitis B.

EXAMPLES

1. In a US case, a blood technician was exposed to the risk of Hepatitis B infection by a needle stick injury. Doctors negligently advised her that if she remained symptom-free for six weeks this would mean she was not infected. Following this advice, she resumed sexual relations with her partner after eight weeks. It was held that her doctors could be liable to pay damages to her partner when he developed Hepatitis B as a result.  

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3 October 1997, para 18.
4 DiMarco v Lynch Homes-Chester County, Inc. 583 A.2d 422 (Pa. 1990).
2. In an Australian case, a doctor negligently failed to consider that a patient of his might be HIV-positive despite a history and symptoms which would have led 'a general practitioner exercising ordinary care and skill [to] have considered a diagnosis of HIV and counselled the need for an HIV antibody test'. The doctor was held liable in damages to a future sexual partner of his patient's who contracted HIV.\(^5\)

It should be stressed, however, that such cases are likely to be extremely rare. Indeed, there does not appear to be any reported example of such a case in the United Kingdom. Such liability has, however, been imposed by courts in Australia, Canada and the United States and it is thought that courts in the UK would take a similar approach.\(^6\)

**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.

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

The matter is dealt with in the GMC’s guidance on serious communicable diseases as follows: \(^7\)

**Giving information to close contacts**
22. You may disclose information about a patient, whether living or dead, in order to protect a person from risk of death or serious harm. For example, you may disclose information to a known sexual contact of a patient with HIV where you have reason to think that the patient has not informed that person, and cannot be persuaded to do so. In such circumstances you should tell the patient before you make the disclosure, and you must be prepared to justify a decision to disclose information.

23. You must not disclose information to others, for example relatives, who have not been, and are not, at risk of infection.

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\(^5\) BT v Oei [1999] NSWSC 1082.
\(^7\) General Medical Council. Serious Communicable Diseases October 1997

In circumstances such as those noted in the GMC guidance, a breach of confidentiality would probably be considered to be in the public interest, and therefore lawful.

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 close contact. In law, the relevant question is whether the healthcare worker can be said to owe a ‘duty of care’ to that close contact, 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 close contact to become HIV-positive.

Here, it is necessary to distinguish between three different categories of case.

(1) The close 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 close contact in such a case. A failure to disclose might therefore be a breach of the duty owed to the close contact, resulting in liability in damages if the contact became HIV-positive as a result.

(2) The close contact is not a patient of the healthcare worker
Although it has been suggested by at least one academic writer (Jones M, 2003) that the courts should recognise a legal duty to third party disclose in such circumstances, the prevailing view (Chalmers, 2004) is that no such legal duty exists. 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.

(3) There is no identified close contact
Where a patient has indicated that he or she does not intend to either practice ‘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].

**A caveat: the National Health Service (Venereal Disease) Regulations 1974**
Some doubt has arisen as to whether disclosure to close 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.

It will be noted that the regulation is not in its terms directed to healthcare workers themselves, but only to the named bodies. The effect of the regulation is not entirely clear, and it has been suggested that a patient is not entitled to rely on it to prevent third party disclosure: ‘perhaps the better view is that a patient has no right to enforce the regulations but must rely on the health authority so to do’. If the regulation was interpreted as placing an absolute prohibition on disclosure by healthcare workers employed by the named bodies, then this would suggest that the GMC guidelines on serious communicable diseases, as quoted above, are incorrect in their terms. (Read literally and in this way, the regulation might also appear to prohibit healthcare workers from disclosing with the informed consent of the patient, which would be a surprising conclusion.

Although it is likely that this regulation does not have such far-reaching effects, their meaning has not been the subject of any court decision, with the unfortunate consequence that it is impossible to be absolutely certain about the legal position. The matter was raised but not decided in the case of Health Protection Agency v X [2005] EWHC 2989, where the HPA sought guidance from the court as to whether it was entitled or required to disclose information relating to the medical records of a patient whom they believed “has passed the HIV virus to one or more persons in the past and is at present having unprotected sexual intercourse with various identified and unidentified sexual partners”. Although the judge heard argument from various parties as to the meaning of the

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9 An earlier version of the regulations (the National Health Service (Venereal Diseases) Regulations 1968) read “shall be treated as confidential except”… rather than “shall not be disclosed except…”. It seems that the circumstances outlined in paragraphs (a) and (b) of regulation 2 were, therefore, an exception to confidentiality over and above those already recognised by the general law, and were not intended to be the only circumstances in which disclosure was permissible. The 1974 revision of the regulations was intended to (1) extend the scope of the obligation of confidentiality beyond those STIs “commonly known as venereal diseases” and (2) extend the regulations to health authorities (see the explanatory note to the Regulations). There is no indication that they were intended to change the obligation of confidentiality into something more onerous, and it may be that the change in wording from “treated as confidential” to “not be disclosed” was inadvertent and not intended to change the meaning of the regulations.) This legislative history was not considered in argument in Health Protection Agency v X (below).
10 Health Protection Agency v X [2005] EWHC 2989, per Munby J at [4].
Regulations,\textsuperscript{11} he did not decide the point or any of the other issues raised, on the basis that Mr X had not been served with the proceedings, nor had the HPA identified any course of action which they proposed to take or the evidence they sought to rely on in support of such action. In those circumstances, the court had no power to give what would have been a purely hypothetical advisory opinion.

It is understood that the Department of Health intends to issue a consultation on confidentiality and disclosure imminently, which will consider whether the 1974 Regulations should be changed.

\textbf{4.4. Disclosure to other healthcare professionals}

As noted above, the GMC guidance on serious communicable diseases stresses that where a patient is diagnosed with a serious communicable disease, a doctor should explain to the patient:

“The importance to effective care of giving the professionals who will be providing care information which they need to know about the patient's disease or condition. In particular you must make sure that patient understands that general practitioners cannot provide adequate clinical management and care without knowledge of their patients’ conditions.”

Where the patient is prepared to consent to third party disclosure, no legal issue should arise. If the patient refused consent, the matter is addressed by the GMC guidelines as follows:

\begin{quote}
“If patients still refuse to allow other health care workers to be informed, you must respect the patients’ wishes except where you judge that failure to disclose the information would put a health care worker or other patient at serious risk of death or serious harm. Such situations may arise, for example, when dealing with violent patients with severe mental illness or disability. If you are in doubt about whether disclosure is appropriate, you should seek advice from an experienced colleague. You should inform patients before disclosing information. Such occasions are likely to arise rarely and you must be prepared to justify a decision to disclose information against a patient's wishes.”
\end{quote}

The legal principles here are, in principle, little different from those involved with regard to disclosure to close 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. However, such cases are likely to arise only very rarely.

\textsuperscript{11} See Health Protection Agency v X [2005] EWHC 2989, per Munby J at [51]-[56].
In routine practice the use of **universal precautions** will be enough to protect health care workers from infection, thereby making disclosure unnecessary to prevent “serious risk of death or serious harm” in health care settings. Furthermore, it is each individual health care worker’s personal responsibility to use universal precautions at all times for their own protection from blood borne infections, many of which are undiagnosed.

**4.4.1. What if the risk to the close contact has become apparent as a result of doctors sharing information?**

GMC guidelines about sharing information between different members of the health care team provide as follows:

"Most people understand and accept that information must be shared within the health care team in order to provide their care. You should make sure that patients are aware that personal information about them will be shared within the health care team, unless they object, and of the reasons for this. It is particularly important to check that patients understand what will be disclosed if you need to share identifiable information with anyone employed by another organisation or agency that is contributing to their care. You must respect the wishes of any patient who objects to particular information being shared with others providing care, except where this would put others at risk of death or serious harm." (GMC, Confidentiality: Protecting and Providing Information (April 2004), Para 10).

Where information has been legitimately shared between doctors in this way, and one doctor has become aware of a risk to a close contact, a breach of confidentiality may be permissible (or required) in the same way as described in 4.3 above. Where information has been improperly shared, this creates a difficult situation. Confidentiality applies to information which has been improperly passed on, but the sharing of information may result in a situation where (a) there is a duty to disclose to a close contact and (b) this will or may make apparent the earlier breach of confidentiality.

It is important to avoid such situations arising by only sharing information about patients where this is in accordance with the GMC guidelines quoted above.

**4.5 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 probably be a breach of the patient’s right to confidentiality. It is for the patient to decide to take that decision and to initiate it with appropriate legal guidance, **NOT** the health care provider. People living with HIV who wish to
take such action are likely to have particular need for specialist advice and support (see Section ----).

**Doctors have no legal duty to report criminal acts, which have already taken place. 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**.

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. If a clinician receives a request from the police for information accompanied by documentation from the patient giving consent for disclosure, the clinician must satisfy her/himself that the consent provided is fully informed and appropriately obtained before disclosing medical information. Attempts should be made for the clinician to talk directly to the patient to clarify this point in person.

Medical records are the property of the individual hospital trust. Any request for access to health care records by an outside agency, including the police should be directed to the Chief Executive of the Trust.

**General practice notes belong to the Secretary of State for health. They can be viewed by patients if requested appropriately via the general practice concerned or through the relevant Primary Care Trust. If third parties wish to see GP notes they must request the patient’s permission. Police have no automatic right to see GP notes. If, however, it is by order of the court notes must be made available**

4.6. **Disclosing information in court**

Although medical evidence 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 in contempt of court.
5. Recommendations for Clinical Practice

As demonstrated by the preceding discussion this is a complex and changing topic. Areas exist where the law remains uncertain and any guidance will perforce be always incomplete. Nonetheless decisions may still have to be taken in situations of legal uncertainty. In such circumstances the emphasis must be to ensure that any decisions taken are reasonable, justifiable and have been made in consultation with other relevant people. The process of decision-making needs to be of the highest integrity and must be clearly documented.

Normally, the overall responsibility for the patient rests with the consultant of record, who should in all cases be clearly identified. However, effective care is best delivered within a multidisciplinary team and various aspects of care may fall to different members of the team. 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.

All healthcare professionals working with people with HIV must be familiar with the ways in which data is stored and the 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, one of whom may be bringing an action against the other 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.

If a patient is involved in a police investigation for issues concerning reckless transmission and needs support, s/he should be immediately referred to THT Direct.

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.

The particular roles of health care professionals in this area 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.
5.1 Advice that should be provided by the clinical team to all patients diagnosed with HIV infection

a. Advice that health care workers give to their patients may come under scrutiny by the courts in the case of criminal proceedings. All advice given to people with HIV should be fully documented in the clinical record. Information is not fixed in this rapidly moving field and advice must be up to date, with the most recent available data being used.

b. 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.

c. Information needs for people with HIV are not static. Giving advice is an ongoing process and as circumstances change so will the advice given. Clinicians should discuss sexual behaviour regularly with patients and ensure that advice given is appropriate for the current state of affairs.

d. 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.

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 of the situation.

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 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.

h. People with HIV should be advised that that there have been successful prosecutions when transmission of HIV has been proved to have taken place and that the risk of prosecution is likely to be higher if the patient
   a. has not disclosed the fact of his/her HIV infection to the sexual partner before having intercourse
   b. has only disclosed his/her HIV infection after having sex,
   c. has given false information to a partner,
   d. is not using condoms.

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 normative beliefs on their patients.

i. 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.

j. A person with HIV who believes they may be the injured party in a case of reckless transmission must be given all the advice appropriate to any person living with HIV. In addition they may need both specialist legal advice and peer support. THT Direct is staffed by workers trained specifically in these issues and onward referral for support would be an appropriate intervention.

In such circumstances 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..

5.2 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 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. 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 immediate and
instantaneous. This makes for a conflict between good clinical practice on
one hand and the possible legal position on the other.

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 that the issues of disclosure are revisited and as
circumstances change appropriate advice and support are made
available.

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

h. 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 the consultant who has
responsibility for their care. Patients should be referred urgently to an
agency with specialist experience and appropriate legal expertise. THT
Direct will be an important resource in such situations, as staff has had
specific training in this issue.

i. In complex cases of continued non-disclosure and failure to follow medical
advice the complexity of the situation will require assessment to be made
on a case by case basis at consultant level or above, using the GMC
guidance as a basis for decision making. Doctors in training and all other
members of the multidisciplinary team who have concerns about such
matters should alert the responsible consultant to the situation.
j. Any action taken should be explained to the patient before hand including reasons for this action

k. These clinical situations can be complex and stressful for healthcare workers. Clinicians caring for patients in this setting may themselves wish to obtain advice and support from their professional and medical defence organisations and the HIV voluntary sector

**5.3. Clinical documentation**

It is important to observe proper practice in documentation of the clinical process and discussions with and about patients as follows:

a. Document clearly in the notes the name of the consultant with overall responsibility for a patient’s clinical care.

b. Document other members of the multidisciplinary team who are involved in the patients care.

c. Maintain full, contemporaneous notes that are dated and signed

d. Document all advice given to patients by whatever route – i.e. note telephone conversations and print and file copies of emails

e. Document discussions that are held about the patient with third parties and other professionals keeping copies of all letters in the main clinical file.

f. Any documentation concerning complaints made by patients should be filed separately from the main clinical record.

**5.4. Dealing with police enquires.**

a. All clinical services should develop local guidance about actions to be taken in the event of police enquires. However some general principles include the following

b. Any requests from the police for information about patients should, in the first instance, be directed to the consultant in charge of the patient’s case.

c. Medical staff in this situation should make contact with their defence organisation for support and advice at a personal level.

d. Trust level management and legal advisers should be informed of any such request immediately and local trust protocols followed.
e. There is no legal duty to give information to the police unless it is at the request of a court. The ethical implications rather than the legal ones are likely to be most problematic for health care professionals in this situation and appropriate advice will need to be sought on a case-by-case basis.

f. Wherever possible patients should be immediately made aware of any request by police for information about them and their situation.
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www.aidslaw.ca/Maincontent/otherdocs/Newsletter/vol10no22005/crimiHIV.htm


Further sources of Information

**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](http://www.bhiva.org)

**British Association of 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/](http://www.bashh.org/)

**African HIV Policy Network (AHPN)**
New City Cloisters, 196 Old Street, London EC1V 9FR
Telephone: +44 (0)20 7017 8910
Fax: +44 (0)20 7017 8919
Email: info@ahpn.org
Web: [http://www.ahpn.org/contact/index.php](http://www.ahpn.org/contact/index.php)


**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](http://www.nat.org.uk/contact/index.cfm)

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

Reports:
http://www.tht.org.uk/informationresources/prosecutions/

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A rapid scan of the laws and rates of prosecution for HIV transmission within
UK Coalition
250 Kennington Lane, London SE11 5RD
Telephone: +44 (0)20 7564 2180
Fax: +44 (0)20 7564 2140
Web: http://www.ukcoalition.org/

UKC survey report:
Criminalisation of HIV Transmission
Results of online and postal questionnaire survey. August 2005

The UK Law and HIV/AIDS Project
http://www.keele.ac.uk/research/lpj/Law_HIV-AIDSProject/index.htm
http://www.keele.ac.uk/research/lpj/Law_HIV-AIDSProject/Links.htm
A variety of useful primary and secondary material relating to the reckless transmission of HIV.
[JA1] NEED TO CHECK THIS WITH RCGP