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Legal responses to HIV & other STIs: professional obligations, medical ethics and public health

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Aim of Workshop

There continues to be concern and misunderstanding about the legal responsibilities of both

- PLHIV and people with STIs to their sexual partners, and
- Clinicians and others concerned with and responsible for care and treatment of PLHIV and those with STIs.

The workshop will consider these issues and consider the response options that are available and appropriate using the case study of a hypothetic patient.

Case

- David X is a 45 year old gay man with no regular sexual partner. He was diagnosed with HIV eight months ago.
- RITA testing indicated that the infection had occurred within the previous 4-6 months.
- In the course of taking his sexual history, David disclosed that he was a frequent user of sex on premises venues and that he used internet sites to find sexual partners.
- At the time of diagnosis David X had a CD4 count of 450-500 and a viral load of approximately 150,000, and this has remained the case.
- After diagnosis the benefits to him of ARVs were explained, as was the importance of condom use. David declines to begin ARV therapy.
- David X missed two of his last three clinic appointments.
- At a meeting of regional sexual health and HIV clinicians and sexual health advisors, doctors from two clinics associated with the hospital where David X is treated reported on two new cases (Mr A and Mr B) of HIV infection among male patients.
- Both Mr A and Mr B gave the name David X as someone with whom they had had unprotected sex in the past year – Mr A three months ago and Mr B ten months ago. Both men say they see him regularly at the sex on premises venue they both go to.

Questions

What, if any, legal and / or professional ethical responsibilities might arise for those concerned with David X's care on these facts? Specifically:

- Has a crime been committed under English law?
- Should David X be reported to the police? If so, on what basis?
- Are there any public health powers that might be relevant in this situation?

Has any crime been committed?

- The law
  - An **offence intentionally or recklessly to cause serious bodily harm** (sections 18 and 20 Offences Against the Person Act 1861) (HIV = serious harm)
  - Prosecution need to prove that **X was cause of complainant's infection** (phylogenetics / RITA)
  - A person is reckless if s/he **consciously takes an unjustifiable risk** (of causing harm)
  - It is a **defence if the complainant willingly and consciously consented to the risk of harm** (i.e. of infection)

Against Mr B?

- David X diagnosed eight months ago
- Mr B last had sex with David X ten months ago
- David X could only consciously be aware of the risk of onward transmission if he knew his status or “deliberately closed his mind” to the possibility that he was HIV positive
- It is possible that Mr B is the source of David X’s infection (don’t jump to conclusions based on timing of diagnosis and who *appears* to be the responsible party)

Against Mr A?

- Phylogenetic analysis
  - If sub-type analysis excludes possibility, no liability
  - If sub-type analysis does not exclude possibility consider circumstances / mental state
- Was David X aware of risk of onward transmission at relevant time?
- If yes, was there consent to risk of infection?
- Not unless there was disclosure
- Do we know this?
- What difference would condom use / ARV adherence and undetectable viraemia make?

1.4 Current Recommendation for Advice

BHIVA Guidelines (2013)

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.

Should you call the police? (Re: Mr A)

- NB GMC Guidance
- You may only disclose personal information about David X
  - If it is required by law, or
  - You have patient's express consent, or
  - It is in the public interest
- There is no lay legal obligation to report suspected crime to police (though for doctors, see GMC guidance on knife and gun crime etc)

Public Interest: GMC Guidance

37. Personal information may […] be disclosed in the public interest, without patients' consent, and in exceptional cases where patients have withheld consent, if the benefits to an individual or to society of the disclosure outweigh both the public and the patient's interest in keeping the information confidential. You must weigh the harms that are likely to arise from non-disclosure of information against the possible harm both to the patient, and to the overall trust between doctors and patients, arising from the release of that information.

38. Before considering whether a disclosure of personal information would be justified in the public interest, you must be satisfied that identifiable information is necessary for the purpose, or that it is not reasonably practicable to anonymise or code it. In such cases, you should still seek the patient's consent unless it is not practicable to do so, for example because:
…
(b) you have reason to believe that seeking consent would put you or others at risk of serious harm
(c) seeking consent would be likely to undermine the purpose of the disclosure, for example, by prejudicing the prevention or detection of serious crime, or
d) action must be taken quickly, for example, in the detection or control of outbreaks of some communicable diseases, and there is insufficient time to contact the patient.

39. You should inform the patient that a disclosure will be made in the public interest, even if you have not sought consent, unless to do so is impracticable, would put you or others at risk of serious harm, or would prejudice the purpose of the disclosure. You must document in the patient's record your reasons for disclosing information without consent and any steps you have taken to seek the patient's consent, to inform them about the disclosure, or your reasons for not doing so.

http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality_36_39_the_public_interest.asp

Disclosures to Protect Others?

53. Disclosure of personal information about a patient without consent may be justified in the public interest if failure to disclose may expose others to a risk of death or serious harm. You should still seek the patient's consent to disclosure if practicable and consider any reasons given for refusal.

54. 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.

55. If a patient's refusal to consent to disclosure leaves others exposed to a risk so serious that it outweighs the patient's and the public interest in maintaining confidentiality, or if it is not practicable or safe to seek the patient's consent, you should disclose information promptly to an appropriate person or authority. You should inform the patient before disclosing the information, if practicable and safe, even if you intend to disclose without their consent.

56. You should participate in procedures set up to protect the public from violent and sex offenders. You should co-operate with requests for relevant information about patients who may pose a risk of serious harm to others.

In this case …

- Calling the police inappropriate for a number of reasons:
  - David X is contactable, and so seeking consent for disclosure should be sought (and even if he were to refuse consent, you would be professionally obliged to let him know what you were intending to do)
  - Critically, YOU don't know whether a crime has been committed (David X may have disclosed and Mr A may have consented to risk), and YOU don't know if a crime will be committed unless you disclose / report
  - There are other ways of managing this …

Public Health Powers

- Health Protection (Notification) Regulations (2010)
  - Duty on RMP to notify Local Authority of cases of
    - Notifiable diseases
    - Other infections if they present, or could present, significant harm to human health
  - Exceptional, not routine
  - Risk of transmission is relevant consideration
  - Guidance clarifies that generally inappropriate for STIs / HIV (see partner notification / contact tracing)
  - Question of clinical / professional judgement
  - For regulations go to: http://www.legislation.gov.uk/uksi/2010/659/contents/made

Health Protection Legislation (England) Guidance 2010

"It is not intended for Part 2A Orders to be routinely used in relation to people who continue to engage in unsafe sex, posing a risk to their partners"

"Where, in exceptional circumstances, an application for a Part 2A Order is considered in relation to a person with a sexually transmitted infection, any benefit from such action in that case should be weighed against possible loss of trust amongst relevant communities in the confidentiality of the local sexual health/GUM clinic"

LA can apply to JP for Part 2A order. The person must have an infection which presents or could present significant harm to human health, and the action ordered must be considered necessary to reduce or remove that risk to human health. Possible orders include:

Submitting to medical examination
Removal to a hospital
Detention in hospital
Isolation or quarantine
Requirement to answer questions about one's health or other circumstances (including about possible contacts)
Monitoring of a person's health and the results reported
Attendance at training/advice sessions on reducing transmission risk
Restrictions on where the infected person goes or whom s/he has contact with

Orders can include one or more of the above requirements, and can apply to individuals or to groups of identifiable individuals. Failure to comply with an order may result in a fine of up to £20,000.

Ordinarily an individual should first be asked to comply voluntarily with any action proposed. They should also receive notice of any application to a JP for an order so they can attend the hearing and, if desired, arrange legal representation. Exceptions to these rights of notice would, however, be made for urgent cases or where there is a fear that an individual might abscond.

Orders can only ever last for a maximum period of 28 days, at which point they need to be renewed with a further application from the local authority to the JP.

Public Health Powers and David X

- Would you notify Local Authority in this case?
- On what basis?
- What decision-making process would you adopt?
- Do you have a clinic protocol?

Some References and Further Reading

Bernard, E., Geretti, A-M, van Damme, A., Azad, Y. and Weait, M. (2007) 'HIV forensics: pitfalls and acceptable standards in the use of phylogenetic analysis as evidence in criminal investigations of HIV transmission' *HIV Medicine*, 8, 382–387

BHIVA Guidelines on criminal law and the clinical team (2013): http://www.bhiva.org/documents/Guidelines/Transmission/Reckless-HIV-transmission-FINAL-January-2013.pdf

Crown Prosecution Service Guidance: http://www.cps.gov.uk/legal/h_to_k/intentional_or_reckless_sexual_transmission_of_infection_guidance/

Dodds C, Weait M, Bourne A, Egede S, Jessup K, Weatherburn P (2013) *Keeping Confidence: HIV and the criminal law from service provider perspectives*. London, Sigma Research. http://sigmaresearch.org.uk/projects/policy/project55/

GMC (2013) Good Medical Practice http://www.gmc-uk.org/guidance/index.asp

HIV Justice Network: http://www.hivjustice.net/ (excellent source of information)

National AIDS Trust resources: http://www.nat.org.uk/Our-thinking/Law-stigma-and-discrimination/Criminal-prosecutions.aspx

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UNAIDS (2008) *Policy Brief: Criminalization of HIV Transmission*, Geneva: UNAIDS, available at http://data.unaids.org/pub/BaseDocument/2008/

Weait, M. *Intimacy and Responsibility: the Criminalisation of HIV Transmission*, Abingdon: Routledge-Cavendish (2007)

Competing interest declaration of value > £1000

Matthew Weait has spoken at company sponsored events for Gilead Sciences (SPRITE Programme) and MSD.

Mark Lawton has received honoraria for speaking and educational development faculty from MSD and for advisory board contribution from ViiV.

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