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Dodds, C; Weait, M; Bourne, A; Egede, S (2015) Keeping confidence: HIV and the criminal law from HIV service providers' perspectives. *Critical public health*, 25 (4). pp. 410-426. ISSN 0958-1596 DOI: <https://doi.org/10.1080/09581596.2015.1019835>

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RESEARCH PAPER

Keeping confidence: HIV and the criminal law from HIV service providers' perspectives

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(Received 17 June 2014; accepted 5 February 2015)

We present qualitative research findings about how perceptions of criminal prosecutions for the transmission of HIV interact with the provision of high-quality HIV health and social care in England and Wales. Seven focus groups were undertaken with a total of 75 diverse professionals working in clinical and community-based services for people with HIV. Participants' understanding of the law in this area was varied, with many knowing the basic requirements for a prosecution, yet lacking confidence in the best way to communicate key details with those using their service. Prosecutions for HIV transmission have influenced, and in some instances, disrupted the provision of HIV services, creating ambivalence and concern among many providers about their new role as providers of legal information. The way that participants approached the topic with service users was influenced by their personal views on individual and shared responsibility for health, their concerns about professional liability and their degree of trust in non-coercive health promotion approaches to managing public health. These findings reveal an underlying ambivalence among many providers about how they regard the interface between criminal law, coercion and public health. It is also apparent that in most HIV service environments, meaningful exploration of practical ethical issues is relatively rare. The data presented here will additionally be of use to managers and providers of HIV services in order that they can provide consistent and confident support and advice to people with HIV.

Keywords: ambivalence; criminal law; HIV; service providers

Introduction

The criminalisation of HIV transmission and exposure has increased globally over the past decade. This trend is most noticeable in high-income countries with concentrated HIV epidemics in Western Europe and North America, while over 20 African countries introduced HIV-specific laws criminalising HIV exposure and transmission in the decade to 2010 (Cameron & Reynolds, 2010). Existing social research offers insight into the overarching public health impact of criminalisation¹ on those who are most likely to be involved in HIV transmission and exposure (Adam, Elliott, Corriveau, Travers, & English, 2012; Burris, Beletsky, Bureson, Case, & Lazzarini, 2007; Dodds, Bourne, & Weait, 2009; Dodds & Keogh, 2006; Dodds, Weatherburn et al., 2009; Galletly &

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Dickson-Gomez, 2009; Horvath, Weinmeyer, & Rosser, 2010; Mykhalovskiy, Betteridge, & McLay, 2010; UNAIDS, 2013; Weait, 2013). This body of work demonstrates that criminalisation has a limited capacity to support HIV precautionary behaviour, such as enabling people to use condoms or disclose their HIV status to a sexual partner, and on balance is likely to have a negative impact on public health goals.

Concern has also been raised about the extent to which criminal prosecutions for the transmission of HIV hamper trusting relationships between HIV service providers and service users (Lowbury & Kinghorn, 2006). Research undertaken in Canada has examined this relationship (Mykhalovskiy et al., 2010; Mykhalovskiy, 2011; O'Byrne & Gagnon, 2012), finding that service providers were often uncertain how to discuss criminalisation and that legal concerns eroded patients' trust in HIV and health services. The law also contributed to a tendency for many providers to frame their HIV prevention advice within a universal moral obligation to disclose known HIV infection in all settings, irrespective of the degree of transmission risk.

In England and Wales, the *Offences Against the Person Act 1861* may be used to prosecute a person alleged to have *intentionally* (Section 18) or *recklessly* (Section 20) transmitted HIV (or any other serious sexually transmitted infection) to another person.² To date, the only convictions have been for *reckless* transmission, for which the maximum punishment is five years' imprisonment (ancillary orders regulating future disclosure and sexual behaviour are also available), and the number of successful prosecutions has been very low. In contrast to many other jurisdictions where research of this type has been undertaken, in England and Wales there is no liability where someone merely exposes another to the risk of transmission (unless there was a deliberate, but failed, attempt to transmit the virus). The prosecution has to prove beyond reasonable doubt that the defendant was the source of the complainant's infection (Bernard et al., 2007). Where the person to whom HIV has been transmitted consented in advance to the risk of transmission, there is no liability (Weait, 2005a, 2005b). For consent to provide a defence, it has to be based on the complainant's actual knowledge of the defendant's HIV infection at the time transmission occurred (Weait, 2005a). In almost all cases that knowledge will be based on the defendant's prior disclosure of status, but there is no independent legal obligation for people with diagnosed HIV to disclose their status prior to sex in England and Wales. However, numerous authors have described HIV status disclosure as a complex and context-specific set of practices, which can be explicit or implicit and understood in a variety of ways by (potential) sexual partners (Adam, Husbands, Murray, & Maxwell, 2008; Adam et al., 2014; Flowers, Duncan, & Frankis, 2000; Green & Sobo, 2000; Klitzman & Bayer, 2003; Marks & Crepaz, 2001; Sheon & Crosby, 2004; Zablotska et al., 2009).

Guidance for prosecutors – familiar to some but not all HIV service providers in this jurisdiction – advises that recklessness probably will not be established where a person has taken appropriate precautions, such as condom use (Crown Prosecution Service, 2011). Health care workers have a responsibility to fully advise a patient on ways to protect their partners from infection, including the use of condoms. In 2013, the British HIV Association released a briefing paper outlining the responsibilities and duties of health care staff with regards to the criminal law and transmission of HIV (Phillips & Poulton, 2013), which developed an earlier draft paper that had been in circulation since 2006 (Anderson et al., 2006). While outlining the circumstances in which a case of HIV non-disclosure could be referred to the police, the more recent guidance stresses:

Health care professionals have a central role to advise and support patients in decision making and to maintain confidentiality (...) There is individual and public interest in maintaining confidentiality; this may be outweighed in order to prevent serious harm to others. (Phillips & Poulton, 2013, p. 3)

It goes on to emphasise that no information should be released to the police unless patient consent has been established or there is a court order requiring this. However, such guidance is optional and not binding, and there has been no audit undertaken on the extent of its successful dissemination. Although some voluntary programmes of embedded professional development for specialist HIV registrars will include a section on criminalisation, there is no training requirement on HIV and the criminal law for clinical staff. Furthermore, in the absence of an HIV sector-wide professional body, there is no equivalent guidance for those working in community-based settings, although a number of organisations have published their own resources about how to manage issues relating to criminalisation for people living with diagnosed HIV (e.g. Bernard & Carter, 2014; Terrence Higgins Trust and National AIDS Trust, 2010).

While taking account of this bio-socio-legal context, the project described here specifically explores the ways that criminal prosecutions for HIV transmission in England and Wales are handled and perceived by those who deliver health and social care services for people with HIV. Our starting point is the argument that normative critiques of HIV criminalisation should extend beyond examinations of the law's influence on sexual and preventive behaviours, in order to gain a better understanding of how the law both shapes and illuminates the broader social relations within which HIV is experienced (Mykhalovskiy, 2011). Essential convergences in sociological investigations of both crime and health care are rarely unified, leading Timmermans and Gabe (2002) to argue that the 'medico-legal' borderland where the law and the clinic directly interact offers opportunity to develop a unified field of study that explores the convergent and divergent means through which these two traditional mechanisms of power can be better understood. They furthermore suggest that explorations of these interactions will help those involved to question the basis for their taken-for-granted norms and procedures – as the borderland is likely to be a site of frequent contestation and ambiguity. HIV criminalisation does not only force an intersection of the law and medicine, it also illuminates the divergent impulses embedded within medicine and public health, as well as diverse approaches to HIV prevention such as harm reduction as opposed to harm elimination. Indeed, we are only able to understand HIV criminalisation in the light of broader social relations and the frequently conflicting values paradigms that construct them.

As Bauman (1991) has described it, one of the key goals of modern society is to root out ambivalence in order to ensure that everything has its place, ultimately enabling a sense of control and peace to prevail. He points out that certainty is at the centre of the twin dreams of legislative and scientific reason. However, what the responses to HIV criminalisation have revealed in those jurisdictions where they have been critically examined, is that just under the surface of the confident professional response to HIV, is a considerable mix of ambiguity and unease. This study examines the specific articulations of this disrupted 'order' among HIV professionals working in England and Wales.

Methods and sample

In 2012, seven focus groups were conducted in England and Wales (Dodds et al., 2013). Of the seven groups, four were undertaken with hospital-based staff (referred to as

Table 1. Professional characteristics.

Participant's workplace		Participant's job role	
HIV or sexual health clinic	48	Physician	21
HIV or sexual health community organisation	22	Nurse	15
		Manager	10
Lesbian, gay, bisexual or trans community organisation	3	Support worker	8
		Health promotion specialist	6
Black and Minority Ethnic (BME) or African community organisation	3	Counsellor/psychotherapist	6
		Outreach worker	5
		Social worker	3
Local authority/social services	2	Administrator/receptionist	2
GP or community health setting	1	Patient representative	2
Acute/emergency health services	1	Public health specialist	2
Other hospital services	3	Midwife	1
Other	3	Other*	11

Note: Some participants ticked more than one workplace setting and more than one job role.

*'Other' job roles included: dietician; pharmacist; clinical psychologist; director of services; peer support worker; team leader; student.

'clinical service providers'/'clinicians') who routinely provide services to people with HIV in areas of contrasting higher and lower HIV prevalence. In the UK, treatment and monitoring of people with HIV are almost exclusively undertaken at specialist HIV and sexual health clinics. Three further focus groups undertaken with 'community service providers' or 'non-clinical providers' comprised professionals providing HIV services in the community.

Recruitment of the 75 participants was undertaken with the support of local key stakeholders, and a summary of workplace types and job roles is given in Table 1. Participants worked in 12 different HIV charities and four hospitals. In addition, two social workers were employed by local municipal authorities.

Each focus group lasted for about 90 min and was facilitated by two researchers. With the consent of participants, the discussions were digitally recorded and transcribed for thematic analysis (Braun & Clarke, 2006) assisted by the use of NVivo 10 software. Participants were asked to discuss their own and their service users' knowledge and perceptions of criminalisation, how and when criminalisation arises within diverse HIV service settings, who raises the issue, and the perceived impact of this issue on broader HIV care and support. Taking each of the substantive areas of the question guide as a starting point, members of the research team worked in pairs to list the emergent themes arising in the annotated transcripts for each group, undertaking constant comparison with the data until each list was exhausted – a method that utilises both inductive and deductive processes (Layder, 1998). The themes were then collated to ensure consistency, ensuring the elimination of overlap prior to thematic coding of the data. Ethics approval was granted by the Research Ethics Committee of the London School of Hygiene & Tropical Medicine. Local research ethics approval was also obtained where necessary.

Results

This section offers a summary of the key findings arising from the thematic analysis, focusing on the following topics: how participants understood the law as it relates to

criminal prosecutions for HIV transmission, how such understandings were transposed into practice and procedure in the workplace, and characterisations of responsibility and public health impact.

Understanding the law

Accurate understanding of and ability to communicate about the law are two important and distinct skills for those who inform service users about the criminal law or are expected to field questions on the topic. Many participants had a basic understanding of the conditions that could lead to a prosecution.

I think the important thing is that transmission actually has to take place. So it is not just about unsafe sex - it is about transmission essentially happening. Somebody has to become positive. (Clinical service provider)

However, many participants expressed confusion about the technical legal meaning of *recklessness*, and what a sufficient defence might be against such a charge. Arriving at a mutually agreed legal definition of *reckless grievous bodily harm* was far from straightforward, with many participants struggling to find accurate and concise means of distinguishing between common-sense uses of *recklessness* and this particular form of criminal liability.

So the way I understood it was, that the law is defined into an act and a mental state. And the original law applied to intention, which is to intentionally and to wilfully desire to do it. And it's kind of flowed out into recklessness, which is sort of omission, or by not caring, or not caring if you transmit. But not taking reasonable precaution, or by not telling people it's kind of involved wider of what my understanding about what the original law was meant to be? (Community service provider)

There were a number of instances where participants' understanding of the law was guided more by a sense of morality as it related to reckless behaviour, than by a firm understanding of the legal principle articulated within the quote above. For instance, a few participants partly based their definition of recklessness on the number of partners with which a person with HIV was having unprotected sex, which is irrelevant to liability.

Although there is technically no legal requirement to disclose HIV status in England and Wales, disclosure behaviours did emerge as a touchstone within focus group discussions. Building personal capacity, and locating opportunities to disclose one's HIV status to potential and current sexual partners were agreed to be important goals within HIV support and prevention services, alongside recognition of the many structural and social factors that need to be in place before safe disclosure is feasible (Adam et al., 2014; Smith, Rossetto, & Peterson, 2008). Participants were keen to point out that where it is safe to do so, disclosure is a key element in developing self-acceptance, building a culture where HIV is increasingly normalised, and contributing to the informed consent of risk for sexual partners. In order to avoid ambiguity (and any ambivalence with regard to their own responsibilities), some service providers advised people with HIV to disclose their HIV infection as the only means to avoid legal liability, therefore favouring a message of universal HIV status disclosure in place of tailored harm reduction.

That is where I go with my casework, that the only way you can be safe from the law is if you are completely honest with people, and telling any person you are having any sexual contact with about your status, because that's the only way that that person can fully consent and they can never have any comeback. (Community service provider)

This was by no means a unanimous viewpoint. Instead, when such ideas about the protective function of disclosure were introduced, they were frequently challenged by those who felt that where a person with HIV had used condoms and/or had maintained an undetectable viral load and thereby considerably reduced the chances of passing on infection (Cohen et al., 2011), they could not and should not be criminally charged.³ Within the groups, such exchanges were characterised by stark contrasts between those who focused primarily on the calculation of risk attached to particular protective behaviours (such as condom use and/or an undetectable viral load) as opposed to those who instead felt that there was a universal moral obligation to disclose, regardless of the risk that a particular sexual encounter might carry. These findings illuminate the way that participants' own comfort with harm reduction (as opposed to risk elimination) influenced how they advised people with HIV about avoiding criminal liability. They furthermore demonstrate that discourses about risk management are far from stable or uniform among this group of professionals.

Practice and procedure

There was considerable variation in each group about the extent to which criminal prosecution for HIV transmission arose within their work settings, and whether it had influenced regular practices such as record keeping or what they considered to be the limits of confidentiality. This is not surprising, given the diverse roles of participants and their different workplace cultures.

Many said that they personally avoided addressing the issue directly with service users, or minimised the detail that they tried to convey, because they lacked confidence in their capacity to talk knowledgeably about the law.

The law is so, kind of, not clear that it is very hard to clarify anything and we do have documentation we give out occasionally from the criminal ... CPS [Crown Prosecution Service]. I would find it to be very hard to be very clear, honestly. It is very vague I think, how we talk. (Clinical service provider)

Some described how one or two colleagues were utilised as an 'in-house' *ad hoc* information resource on the law, and this was linked to discussions in all groups that highlighted participants' lack of access to qualified criminal legal advice. Very few mentioned or demonstrated awareness of the British HIV Association's position papers about the appropriate management of this issue in clinical settings described at the outset of this paper (Anderson et al., 2006; Phillips & Poulton, 2013). Perhaps it is not surprising then, that communication practices varied considerably, depending on a participant's certainty in their own understanding of the law, as well as their perspective on the appropriateness of raising the topic in a particular consultation.

Most providers talked about the way that their ability to build a trusting relationship with service users was reliant upon a values-led approach that was neutral, 'user-led' and responsive to the particular needs of the individual in front of them for a short period of time. In each group, some described how they judged the best means of

approaching the topic of criminalisation in this light. They acknowledged this was complex information to convey, which needed to be well-timed and appropriately tailored for each individual, although there was a clear pattern that emerged between clinical and community-based service providers.

In all of the HIV clinics where this research was undertaken, information about criminal prosecutions was provided to patients, and many clinicians described routine practices such as its inclusion as a topic to be covered on standardised checklists for new patients, to ensure it had been discussed.

I check if the health advisor has discussed it with them [...] and refer them on if needs be.
(Clinical service provider)

In contrast, those working in community organisations frequently waited until a service user raised the issue before discussing it, as most felt their primary function was helping to meet the immediate and tangible needs that their service user brought to the consultation (such as emotional support, health information, housing advice). However, there was a degree of professional decision-making employed in these settings as well, as some working in community settings said there were circumstances in which they might raise the prospect of a criminal prosecution where a service user with HIV reported that they engaged in higher risk behaviours.

In the main, service providers discouraged their service users from making criminal complaints (where this had arisen).

I cannot think of any case where someone came and said they wanted to prosecute and then actually walked away and still wanted to prosecute. As soon as you give information and emotional support, you find an immediate shift. Especially if you signpost them onto services. You see a change of mind very fast if you support them in the right way.
(Community service provider)

Nonetheless, a few talked about the importance of supporting all service users, including those who had independently decided that they wanted to make a criminal complaint, and there were two further individuals who each described at least one occasion where they had asked a patient if they had considered contacting the police about their infection.

When it came to record keeping, it was mainly those working in clinical settings who tended to document as much detail given by the patient as possible (including sexual behaviour that carried a risk of HIV transmission to others), alongside detail about information and advice imparted by the clinician. Some said that rigorous standards of documentation were an essential component of medical practice, and their practice had not changed in the light of criminalisation. Many clinical participants said that good documentation would also protect any professional whose decisions or actions were scrutinised in the future, while others wanted to maintain records that may help to defend a patient, thereby keeping careful records of protective or precautionary behaviour, or disclosure whenever it was reported. Other clinicians described how their awareness of criminal prosecutions made them acutely aware of the need for even more rigorous documentation than they had undertaken in the past. Across the groups, it was often senior clinical participants who raised the role of the new patient checklist which (among other things) had helped to ensure that all new patients were informed about the criminal law, while at the same time protecting professional liability, as it provided

a means of systematically recording that the topic had been covered with each individual patient. At the same time, nurses and other junior staff revealed that this 'solution' failed to address their lack of confidence regarding how to get this information across clearly and unproblematically.

In contrast, those working in community-based organisations tended to have been influenced by criminal prosecutions in the opposite direction. Some said they were now far more cautious about the content of service-user records, and their security, due to a renewed awareness that any records could be requested by the courts.

If I am working with a person who has high risk behaviour I do not document it in detail, just in case further down the line there is someone with a warrant. (Community service provider)

There were also, however, participants from community-based organisations who described how their record keeping might function as a means of supporting a service user if a criminal complaint was ever made against them. For instance, many would carefully record when disclosure to a sexual partner was reported, or when problems that had prevented disclosure (such as unequal or abusive relationships) were described, in case that might be important to someone's defence in a future criminal trial.

Concerns about records being seized by police in criminal investigations for HIV transmission prompted discussion with participants about confidentiality and how this was explained to service users. Most participants working in both clinical and community settings said that they took care to explain to service users how their data would be protected, while also mentioning that there were specific circumstances in which they may be required to release it to the police.

Responsibility and public health

Unlike some of the other topics described above, there were few clear patterns between the ways that clinical or non-clinical providers discussed responsibility and public health. Some participants argued that as long as a person with diagnosed HIV had full awareness of how to prevent HIV transmission and was aware of the potential consequences, they bore primary responsibility for taking precautions.

... if someone has a known infection, they should assume responsibility for themselves to keep up to date with the advice that has been given to them. (Clinical service provider)

However, this was a minority perspective in nearly all focus groups, with most participants arguing that allocation of responsibility was not uniform and that it needed to be understood within specific circumstances that can constrain precautionary behaviour. These participants focused on the social structures shaping the lives and experiences of people with HIV, such as pervasive social and economic inequality, power imbalance, HIV stigma and fears for safety and security.

The woman may not have the power to be able to truly consent to having sexual relationships. Plus, added on to that, she definitely doesn't have the power to be able to disclose. But she also, because of immigration and things like that, may not have the power to leave at that moment. So, I mean that is where recklessness becomes really ... I mean, is it reckless behaviour if it is potentially lifesaving for her? (Community service provider)

Some took this point further, arguing that consensual sex implied a shared responsibility for taking precaution against possible infection.

- Researcher: Thinking more generally, where do you feel responsibility for HIV transmission lies?
- P1: Assuming it's consensual and not coerced. Then it's shared.
- P2: As long as they know about condoms and safer sex, everyone should be responsible for their own sexual health. (Clinical service providers)

Uncertainties about professional responsibilities and ethical obligations of HIV service providers pervaded every focus group discussion. Sometimes these concerns arose from uncertainty about the extent of professional legal liability in such circumstances. Participants debated the extent to which service providers owed a primary responsibility to the service user in front of them, or whether there was also a similar obligation to protect the health of others who may be at risk of infection.

It's about duty of care as well. We have a duty of care to the index patient but not necessarily the person who might be infected. (Clinical service provider)

Certainly not all participants took the same view, and these discussions revealed that service providers wanted to better understand their own legal liabilities, and to clarify the extent to which professional ethical guidelines may consider duty of care as a rationale that *enables* them to consider a breach in confidentiality, rather than *obliging* them to do so, as evidenced in the following comment.

I guess ... [if] ... you are aware of who they are potentially putting at risk. Where there is a certain responsibility for you to breach confidentiality. [agreement from others] (Clinical service provider)

Underlying these discussions was a pervasive sense of professionals feeling torn between duties to service users and to the broader health of the public. One participant described a case where a patient who was known to be abusive towards sexual partners had been named as a sexual contact.

It was a very uncomfortable position to be in, because I still didn't say, 'Are you going to take him to court?' or whatever. I would have happily listened and given them information if they wanted to, or if they had suggested it, but you know, you kind of have two hats on: you have got your clinical hat on, and your public health hat on. You do not want to be colluding with people like this guy ... they are a minority, but they are potentially involved in transmission. (Clinical service provider)

There were also participants who made it clear that for them, such conflicts were rare, as they made sure not to allow their own moral positions to influence their dealings with service users.

If they are knowledgeable and consenting in some ways, to be honest, it is none of my business. (Clinical service provider)

These debates about the practice of public health ethics and professional ethics among HIV health and social care service providers appeared in many cases to be the first time that such discussions were widely aired between colleagues. Such issues

tended to be approached with caution and hesitation in the focus group format, with those in more junior or inexperienced positions tending to defer to the more senior and confident voices in the room. This raises interesting questions about the practical governance and management of ethical discourse and practice in HIV service settings, to be followed up in the discussion below.

Despite the many approaches to criminalisation described above, no one, when directly asked what they thought prosecutions accomplished in public health terms, was able to describe a beneficial public health outcome. This is an interesting finding given that there were some participants who gave accounts of recommending or supporting the making of a criminal complaint, accompanied by a greater number who experienced a conflict between a duty of care to their service user and to those at risk of acquisition. Perhaps this is because such providers found that criminalisation helps to manage moral concerns about behaviour, by providing punishment for past transgressions, rather than any sense that they were actually likely to bring about wider public health gains.

In contrast, others felt that criminalisation brought only harmful consequences for their working environments, and by extension, for health outcomes among their service users.

I think it also affects the trust relationship between workers and service users, and clinicians and service users at times, sometimes in quite a negative way. You see quite a few people who have been damaged by the process. And it's a long bridge-building process to re-establish the trust in procedures. (Community service provider)

This comment is representative of the many concerns that participants raised about the ultimate impact of criminal prosecutions, which can lead to increased stigma, reduced trust between service users and providers, and traumatic consequences for those who get involved in such cases. Such findings help to clearly demonstrate that the outcomes of criminal justice can be directly at odds with the goals of public health and individual well-being. Members of one clinical team talked in detail about the detrimental mental health impact that involvement in a case had on one complainant:

It felt like we were going back to the day when she got the diagnosis, and we stayed there with her for about six months in terms of the infection and not being able to move on from how this happened to her. (Clinical service provider)

Reviewing this last set of findings as a whole, the vast majority of participants felt that if they were to overemphasise potential liability and criminal responsibility in discussions with people with HIV, this would have little benefit, and threatened to erode the trust and stability that had been so carefully maintained in order to enable vulnerable people to access their service. It was because of these concerns about potential damage that most participants said they would not want to directly support or provide evidence for the prosecution of cases. At the same time, many participants felt that they had inherited a responsibility for imparting accurate legal information to service users with HIV, even though this was not a part of their job description or training. Considerable anxiety about what constituted professional responsibility within this context was on display during the focus groups, arising from a widespread lack of confidence in conveying accurate legal information and advice while also striking a correct balance between informing and frightening service users. In such conditions, most participants expressed frustration about expectations within their professional roles and practices that felt at odds with their overriding professional responsibility to attend to the needs of the individual.

Discussion

The aim of this study was to better understand how the criminalisation of HIV transmission interacts with the provision of HIV services in England and Wales from the perspective of those delivering HIV treatment, care and support. In doing so, we also exposed some of the fragile and divergent interpretations of professional roles and responsibilities within and between institutional networks, as well as the values that underpin these. This discussion focuses on the sense of professional ambivalence that frequently comes to the fore in the face of HIV criminalisation, driven by the challenging nature of attending to public health values while working as a front line HIV service provider. We also consider a range of ways that participants sought to deal with this ambivalence in comparison with other research findings.

The majority of study participants described feeling caught between a clinical medical ethics of individual autonomy (grounded in human rights), and a public health ethics which emphasises the good of the collective (O'Neill, 2002). This tension has long existed, but is frequently obscured by a discourse of healthcare ethics which tends to be dominated by narratives of individual autonomy, developed to help manage the power dynamics in individual patient–doctor relationships (Gostin, 2003; Mann, 1997; O'Neill, 2002). Most study participants described the ways in which criminalisation had forced them to confront the divergent imperatives of individual autonomy, criminal justice and public health, often resulting in ambivalence about their professional values, which in turn had led on to a deep unease around the entire topic.

In essence, we would argue that these service providers are confronting a core problem with aspirational public health discourse. In the main, key public health values are narrated (both in training and in available academic literature and policy documentation) for the benefit of public health officials and policy makers. Frontline providers of health, social and care services outside of the strict 'public health' sphere may find that they have difficulty translating such values into tangible, immediate decisions about advice and intervention at the individual level (Gostin, 2003; Jennings, 2003), with little sense of 'who has to do what for whom' (O'Neill, 2002, p. 8). Criminalisation appears to have nudged open pre-existing (yet routinely unacknowledged) fault lines in professionals' values and responsibilities frameworks. This dilemma is both produced and disrupted by the criminal law's entry into the field of HIV, given that no participants could locate any public health benefits arising from prosecutions for HIV transmission. At a practical level, some participants constructed solutions to help avoid or ameliorate such ambivalence, each being subject to varying degrees of acceptability among participants.

In the main, the concept of 'the responsible person with HIV' was largely undisturbed among service providers in their routine engagement with clients and patients, as most described people with HIV as being very cautious to minimise onward transmission risk. When outliers emerged (people with HIV who reported having unprotected intercourse with multiple partners over time) a small number of service providers in each focus group maintained order within their values systems by casting them as irresponsible. Such professionals had formulated a personal legal definition of *recklessness* as it related to HIV that would include any person with HIV whom that service provider had deemed to be irresponsible. The creation of a moral order of this type helped such participants avoid the values fault lines described above. This was most evident among those who described how they used the criminal law as a means of warning errant service users about the implications of their ongoing risky behaviour – and they

described a feeling of empowerment or relief about being able to use the law as an externalised tool to help dispel their moral unease. In a few isolated cases, this went further, with service providers suggesting and supporting the pursuit of a criminal complaint. In our study, sharp discussions emerged between participants who maintained that successful HIV prevention was predicated upon harm reduction, and those who instead had started to promote universal HIV disclosure as both legally and morally safer. Just as Mykhalovskiy (2011) found, this application of the criminal law to HIV enables some professionals to taking up the opportunity for moral entrepreneurship, thereby adopting a rule enforcer role (Becker, 1963).

Many providers wanted a simple universal set of HIV prevention messages to use with people with HIV, demonstrating that commitment to HIV harm reduction (boasting a veritable toolbox of behavioural choices for people with HIV⁴) is contested and patchy. Despite the currents of constant technological change which shape the landscape of HIV prevention, criminalisation's inherent focus on responsibility for HIV sero-status disclosure among people with HIV forces professionals to decisively position their personal and professional values to an extent that has not been demanded of them previously. Some demonstrated greater capacity to manage these demands than others.

A related response to professional ambivalence was clinical service providers' description of systematic note-keeping. In the clinical sphere, advice and discussion about criminalisation became incorporated into a pre-existing checklist and documentary working culture – which also served to guard against professional liability, again echoing Mykhalovskiy's (2011) findings. Others (particularly those working in community settings), described a response to criminal prosecutions that had taken them in the opposite direction, in that they had actively reduced the degree of detail in their notes in order to reduce the likelihood that these could be used in a criminal case. Reliance on managerial checklists has long been recognised as a key feature of allocating roles and responsibilities within large institutional systems (Smith, 2005). Such findings bring to mind Bowker and Leigh Star's notion of 'information infrastructures' (2000) which articulate the modern information society's response to the moral imperative for order and classification. Their work draws out the tension between the benefits of classification, and the problems of rendering responses, motivations or actions invisible – such as some junior members of clinical staff in our study who often expressed unease about having to raise the issue of criminalisation which was a new addition to the patient checklist. Their managers' confidence that the matter was being dealt with was predicated on the existence of the information infrastructure, rather than necessarily because of knowledge about how these conversations were actually undertaken. On numerous occasions, the focus group participants pointed out that it was the first time they had ever been asked to explore these feelings of unease and professional confidence with colleagues.

When asked directly about the influence of criminalisation on working practices, a sizeable proportion of our participants actively rejected the idea that their practices had been unduly influenced by the criminal law. Therefore, in contrast to Mykhalovskiy's (2011) findings where there was a sense that having 'an eye to the law' was a pre-eminent and increasingly overriding concern in HIV service provision, a substantial number of our participants argued that correct data management and counselling practice proceeded without hindrance by such concerns. These assertions did not always correspond with specific discussions about record keeping. While our participants could not rule out self-censoring by service users, there was no evidence to suggest that the

law had made providers afraid to talk with them about sex. The differences between our work and that undertaken earlier could be in part because key elements of criminal liability differ significantly between the UK and Canada.⁵ Yet, in more recent research among HIV specialist nurses in Canada, Sanders (2015) reveals that changes to documentation practices in the light of criminalisation include a mixture of those who document more, and those who document less as a direct result of potential use of professionals' notes in criminal proceedings, similar to our findings.

Conclusion

Bauman (1991) argued that the key task of modernity is to make order of disorder, often by enforcement of a singular legislative logic. His understanding of the aversion to ambivalence in modern systems – underlined also by Smith (2005) and Bowker and Leigh Star (2000) – help in the critical examination of our findings, where we see a prevalent impulse to locate clean and clear mechanisms to reassert control. Indeed, we also found some opposition to this dominant tendency, voiced by those who saw practical and ethical value within the multiplicity of choice and the wide array of perspectives and outcomes that made up the diverse experience of people with HIV. In both responses, we can observe how professionals respond (and what tools they reach for) when their values systems are complex and at times contradictory. A few existed comfortably within that space of ambivalence, where they felt the pull of divergent considerations; most did not.

It is not that long since clinical training better enabled students to prepare for such circumstances. A longitudinal investigation of 1950s medical training in the US demonstrated that at that time, doctors were trained to 'sit' with uncertainty as a necessary component of their work and to develop the confidence to manage it as a part of their approach to patients (Fox, 1957). We can only wonder how many professionals already working in and entering the HIV sector in the current era (in both clinical and non-clinical settings) are adequately prepared to deal with the moral and professional complexities that inevitably emerge. Arguably, where such tensions have been papered over through routinisation or silence, HIV criminalisation has stripped back this veneer. If so, one of the key recommendations arising from this research is that staff teams will benefit from regular collective discussions about HIV and the criminal law, as well as other issues that pose moral or ethical dilemmas. Such discussions among staff might encourage greater consistency in approaches and communication styles, and the mixing of clinical and non-clinical service providers in such discussions may facilitate exchanges of views and approaches. The focus groups themselves appeared to offer a rare opportunity for staff teams as well as mixed professionals to collectively consider the issue.

Ultimately, the findings offer us insight into the various ways that criminalisation exposes key tensions for HIV service providers. Providers often feel at least partially responsible for HIV prevention and public health themselves, even if they recognise the responsibility and choice available to service users. This study has revealed the layers of complexity which criminalisation adds to the relationship between service providers and service users, both in clinical and community settings. It has generated unease, due to its disruption of a coherent set of professional ethics. In so doing, it has impacted on the ways in which the majority of HIV service providers, whose primary concern is the health and well-being of their service users, understand the scope and substance of their

role. The exploration of such issues is something that is best tackled directly, and we hope that these findings will encourage practitioners to consider taking the time to talk with and listen to colleagues' contrasting standpoints and opinions. Ultimately, this should lead to greater transparency and coherence – not only in working practice related to HIV criminalisation, but also in underlying professional values.

Acknowledgements

We would like to thank those who took part in the research and who helped to arrange and host focus groups, as well as Gary Hammond and Kathie Jessup for their administrative support throughout. We also thank participants of the international CIHR funded workshop, *The Public Health Implications of Criminalising HIV Non-disclosure, Exposure and Transmission* held in Toronto in April 2013 for their feedback on an earlier draft. Particular thanks are owed to Eric Mykhalovskiy for his encouragement and support as well as the anonymous reviewers whose suggestions were warmly appreciated.

Disclosure statement

The authors have no financial interest or other benefit arising from this research.

Funding

This work was made possible through financial support provided by the Monument Trust.

Notes

1. Terms such as 'criminalisation', 'criminal prosecutions', or 'HIV and the law' may variously be used in a range of settings to refer to any prosecutions for a range of illegal behaviours implicated in HIV exposure (such as sex work or injecting drug use). However, this paper only uses these terms to refer to criminal prosecutions for the *sexual* transmission of HIV.
2. It should be noted, that the Court of Appeal has affirmed that genital herpes, a far more common condition than HIV, also falls into the category of "serious": *R. v. Golding* (2014) EWCA 889.
3. As noted above, the Crown Prosecution Guidance document (2011) in place at the time of the research did acknowledge such protective measures as available defences in such cases, but certain knowledge of these issues was rare.
4. Harm reduction with regard to the sexual transmission of HIV can include a range of preventive practices which may variously include: condom use, ensuring the person with HIV is the receptive sexual partner, only having unprotected intercourse with other people who have diagnosed HIV, ensuring a reduced or undetectable HIV viral load prior to unprotected intercourse, use of pre-exposure prophylaxis by the individual without HIV infection, etc.
5. In England and Wales it is only sexual behaviour that actually results in serious disease transmission (or proof of intent in the absence of transmission) that can be successfully prosecuted under the OAPA 1861. As a result, those working in jurisdictions where HIV transmission is essential to a criminal charge may not be as concerned as professionals in other jurisdictions about being in possession of knowledge about service users' sexual behaviours.

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