



May 2007

v22 n5

FOCUS

A Guide to AIDS Research and Counseling

Sex, Crimes, and HIV

Zita Lazzarini, JD, MPH, Ross K. Friedberg, JD/MPH cand.

In 2002, South Dakota authorities arrested and charged a popular college student and basketball star with multiple counts of “knowing exposure to HIV,” for having unprotected sex with his girlfriend and at least two other students after having tested HIV-positive. He was the first person in South Dakota to face such charges under a law that makes this a felony.¹

Such cases pose the question: When is it a crime for a person with HIV to have sex? The answer is: it depends—on what state that person lives in, how the state courts interpret that state’s laws, and how police and prosecutors enforce the laws.² In most states, it is legal for a person with HIV to have sex if that person discloses his or her HIV status to a partner before having sex and the partner consents to engage in sex knowing that the individual is HIV-positive.

Most states’ laws do not clearly make condom use an alternative to disclosure and consent. In at least one state, Maryland, neither condom use nor disclosure is adequate protection against possible prosecution.³ In all states, however, these laws are rarely enforced. This article reviews the range of U.S. state laws on this topic, briefly describes other countries’ laws, and explores how the trend of criminalizing HIV exposure and transmission has affected people with HIV and HIV prevention efforts.

Laws Criminalizing HIV Exposure

Long before the appearance of HIV, U.S. states established laws criminalizing activities that were likely to expose individuals to infectious diseases such as yellow fever, smallpox, and tuberculosis. As recently as 2002, at least half of the states had such communicable disease laws (which typically imposed misdemeanor penalties) on their books.

During the late 1980s and the 1990s, approximately half of state legislatures adopted HIV-specific laws that criminalized a range of behaviors related to HIV. Scholars have suggested that many of these laws were passed in haste and in a climate of fear.³ These fears were partly due to the unique characteristics of HIV; unlike many other communicable diseases, HIV is incurable and, at the time many of these laws were passed, it was uniformly considered fatal. There was also the widespread misperception that HIV could be easily transmitted through casual contact. Moreover, nearly all these state laws punished violations as felonies.

As of 2002, 24 states had passed criminal statutes that directly prohibited behavior associated with potential exposure to HIV. Examples of HIV-specific laws include laws that prohibit individuals with HIV from sharing injection equipment, donating blood or organs, having sex without disclosure to partners, and spitting, biting, or throwing or smearing blood, feces, or other body fluids. All except three states (Maryland, Kansas, and Washington) make some exceptions, permitting sex if the HIV-positive person gains consent from a partner or uses a condom. Fifteen states have also modified existing criminal statutes related to other crimes, such as rape and prostitution, with provisions that impose additional penalties on perpetrators who exposed others to HIV in the course of committing another crime.²

Overall, the HIV-specific statutes that apply to sexual exposure diverge from accepted public health messages in several ways. First, they focus on disclosure as the primary means of prevention, rather than rewarding or emphasizing safer sex practices, including condom use. Second, most statutes make no distinction between higher-risk activities (for example, unprotected anal sex with an HIV-positive insertive partner) and lower-risk activities (for example, oral sex with

References

1. Fountain J. *After arrest, campus queues for HIV tests.* New York Times. May 1, 2002.

2. Lazzarini Z, Bray S, Burris S. *Evaluating the impact of criminal laws on HIV risk behavior.* Journal of Law, Medicine and Ethics. 2002; 30(2): 239–253.

3. Galletly C, Pinkerton S. *Conflicting messages: How criminal HIV disclosure laws undermine public health efforts to control the spread of HIV.* AIDS Behavior. 2006; 10(5): 451–461.

Editorial: Crime Drama

Michelle Cataldo, LCSW, Clinical Editor

As a culture, we are fascinated by crime dramas, both of the entirely fictional variety and those that are “ripped from the headlines.” *Law and Order* is the most successful franchise in television history because it combines the excitement of drama and the comfort of a set “procedure.” A crime is discovered. Earnest investigators conduct interviews. A suspect is identified, and ultimately convicted, often breaking down and confessing on the stand.

At the end of such a procedural drama, responsibility is clear, and guilt is punished. Clinicians in such scenarios are portrayed as either helpfully agreeing to release information, or, if obstructionists, doing so only reluctantly under subpoena. Ultimately the records are always released and everyone is a little better off because the “truth” came out.

Media coverage of knowing, purposeful HIV transmission can be

similarly dramatic. As Zita Lazzarini and Ross K. Friedberg note in their article, while such cases appear to be rare, and few cases are prosecuted, accounts of such cases are often both lurid and widely reported. Lazzarini and Friedberg’s piece also explores the theory behind laws that criminalize HIV exposure and transmission and asks how well these laws actually protect HIV-negative members of the public.

The question of whether an HIV-positive person should be held criminally liable for not disclosing his or her HIV status is controversial. But if you really want to incite passionate debate among HIV providers, ask them if clinicians have a *Tarasoff*-type “duty to warn” unsuspecting partners in such situations.

As Tiffany Chenneville reports in her article, the law on this point is often unclear and variable by state. Further, the classic pepe-

trator from television and newspapers—the angry, perhaps anti-social client intent on infecting others—is not the client we usually see. Most often, the clients we work with have not yet figured out how best to tell intimate partners—but might with help and time. In such cases, turning delayed disclosure into a crime may subvert the very prevention goals the law seeks to promote.

While legal mandates and ethical guidelines regarding HIV status disclosure exist, there are few clear-cut absolutes. However, clinicians can take a number of steps to help themselves, their clients, and their clients’ partners. They can learn about local laws and professional guidelines, seek consultation, work with clients to reduce risk, and document their interventions. Ultimately in this area of clinical practice as in so many others in the real world, black and white drama fades to shades of gray. Fortunately, clinicians are accustomed both to working in these gray areas and to challenges that take more than an hour to resolve.

4. California Health and Safety Code, section 120291.

5. Marks G, Richardson J, Crepaz N, et al. Are HIV care providers talking with patients about safer sex and disclosure?: A multi-clinic assessment. *AIDS*. 2002; 16(14): 1953–1957.

6. Wolf L, Vezina R. Crime and punishment: Is there a role for criminal law in HIV prevention policy? *Whittier Law Review*. 2004; 25: 821–825.

7. Burris S, Scott C, Beletsky L, et al. Do criminal laws influence HIV risk behavior? An empirical trial. *Arizona State Law Journal*. 2007; <http://ssrn.com/abstract=977274>.

an HIV-positive receptive partner). Finally, these laws tend to shift the burden of prevention away from one of shared responsibility between infected and uninfected people and toward a reliance on HIV-positive individuals to disclose their status.³

In addition to these HIV-specific statutes, all U.S. states have traditional criminal laws that can be used to prosecute individuals for exposure to or transmission of HIV. These statutes typically cover crimes such as murder, attempted murder, and assault or assault with a deadly weapon. From the perspective of prosecutors, however, these laws have not been well suited to prosecution of individuals engaging in consensual sex, since they raise difficult issues of proof including intent, causation, and even definition. For example, can HIV itself be considered a dangerous weapon?

As is apparent from the description above, many of these state laws contain broad language covering a wide range of behaviors, some of which pose little risk of HIV transmission. Most laws do not require that the defendant intend to cause harm. In contrast to this norm, the law in California criminal-

izes only a narrowly defined set of behaviors associated with HIV exposure and transmission. Under the provision in California related to otherwise legal sexual activity, only individuals who engage in sexual activity with the specific intent to infect a partner are guilty of a crime. The law defines “sexual activity” in a way that reflects the real possibility of exposure to HIV: insertive or receptive vaginal or anal intercourse.⁴

Many Laws, Few Prosecutions

Although virtually all states have the capacity to prosecute people with HIV under criminal law, communicable disease law, or HIV-specific laws, prosecution is relatively rare. A search of criminal cases during the period from 1986 through the end of 2001 revealed only 316 unique prosecutions throughout the United States. The same search uncovered no HIV-related prosecutions under general communicable disease laws and no prosecutions of any kind in about a quarter of states. Only 13 jurisdictions had 10 or more prosecutions each, and only six states (California, Florida, Illinois, Missouri,

Ohio, and Pennsylvania) and the military had 15 or more prosecutions each.²

More than 70 percent of all the 316 prosecutions involved behaviors that were already illegal (prostitution, nonconsensual sex, and other forms of assault). About two-thirds of the total cases involved sexual activity. These included consensual sex in which the defendant did not inform a partner of his or her HIV infection or in which the partner's knowledge and consent to the exposure was disputed. Only a few cases involved selling blood, and no case involved HIV exposure through needle sharing. Seventy-five cases, however, involved activities—spitting, biting, or scratching—that posed little or no risk of transmission.²

Among the 228 cases for which there is information on final disposition, 80 percent resulted in a conviction on the HIV-related charge or resulted in a heightened penalty because of the defendant's HIV status.² Between 1986 and 2002, California had at least 26 prosecutions. Of these, 15 involved sexual exposure (including six cases involving HIV-positive prostitutes), eight were based on spitting or biting by an HIV-positive person, and in one a contaminated syringe was used as a weapon.

There is no conclusive explanation for the relative rarity of prosecutions. Empirical studies indicate that a substantial minority of people with HIV sometimes have sex without disclosing their serostatus.⁵ Victims may be unwilling to come forward and exposure is difficult to prove. Additionally, except in the most egregious cases, public health officials have not advocated for prosecutions.

The cases that have been prosecuted, however, have received considerable and even lurid media attention. For example, in 1997, Nushawn Williams was charged based on evidence that he had had sex with 48 women and girls (and infected 13) after testing HIV-positive. Race, sex, mental illness, and drug use featured prominently in many of the over 700 newspaper stories that reported on this case. Williams, an African American, was arrested in a largely White small upstate New York

town. Not only had he, and some of the women, been involved with drugs during the time of the exposures, but there was also evidence that, because of mental illness, he did not believe health officials who told him he had HIV. He was later diagnosed with schizophrenia.⁶

Efficacy of Criminal Penalties

Theoretically, criminal laws could work in at least three ways to reduce the spread of HIV. First, by putting people engaged in

unprotected sex in prison, these laws could “incapacitate” people who could transmit HIV (or at least limit their sexual contact to the prison setting). Second, by imposing stiff penalties upon people convicted of these acts, the laws could deter others from knowingly exposing a partner. Third, by clearly expressing a social consensus that such behav-

Nearly every U.S. jurisdiction has laws that can prosecute HIV exposure or transmission, yet such prosecutions remain rare.

ior is wrong, these laws could set social norms that would become self-regulating through peer pressure. There is very little evidence, however, that either traditional criminal law, communicable disease law, or HIV-specific laws have actually reduced the spread of HIV.

A team of researchers from the University of Connecticut, Temple University, and Harvard Medical School interviewed 499 people from New York and Chicago (including HIV-positive, HIV-negative, and serostatus-unknown individuals) who had engaged in behaviors that could transmit HIV. Roughly half of the participants were injection drug users and half were men who have sex with men. The investigators sought to determine whether the presence of an HIV-specific criminal transmission and exposure law, or the belief that such a law existed, had any effect on behavior. Further, they tried to discover whether any of the three theoretical models discussed above explained participants' responses. While the majority of participants believed that it was wrong for a person with HIV to expose his or her partners to the virus and that it was right to disclose infection to those partners, these beliefs were not related to either the existence of an

8. Mears A. *The criminalization of HIV transmission in England and Wales: A brief review of the issues arising*. Current Opinions in Infectious Diseases. 2007; 20(1): 47–53.

9. *People Living with HIV/AIDS Victoria. HIV and the Law. South Yarra, Australia: People Living with HIV/AIDS Victoria, 2007; <http://www.plwhavictoria.org.au/HIV%20%20The%20Law/hiv%20%20the%20law.htm>*

10. *Australian Federation of AIDS Organizations Inc (AFAO). AFAO Workshop on Criminalisation of HIV Transmission: Report. Newtown, Australia: AFAO 2006; http://www.afao.org.au/library_docs/policy/Criminal_prosecution_forum_Nov06.pdf.*

11. *UNAIDS. International Guidelines on HIV/AIDS and Human Rights, 2006 cons. version. Geneva: United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, 2006.*

12. *WHO. WHO Technical Consultation in Collaboration with the European AIDS Treatment Group and AIDS Action Europe on the Criminalization of HIV and Other Sexually Transmitted Infections. Copenhagen: WHO Regional Office for Europe, 2006; http://www.euro.who.int/Document/SHA/crimconsultation_latest.pdf.*

HIV-specific transmission or exposure law or to the belief that such a law existed.⁷

The Climate Outside the United States

Many other countries have criminalized specific behaviors associated with HIV exposure and transmission. Since 1988, when the first HIV transmission-related prosecution occurred in Europe, European countries have collectively convicted more than 130 defendants on HIV-related charges, often resulting in prison sentences. In the United Kingdom, authorities prosecute individuals for transmission of HIV under the 1861 Offences against the Person Act. Although the act does not contain any HIV-specific language, it empowers authorities to prosecute individuals found to have intentionally or recklessly transmitted HIV to another person. The first HIV-related prosecution in the United Kingdom took place in Scotland in 2001, and at least eight prosecutions and seven convictions have occurred since.⁸

In Australia, the criminal laws associated with the transmission of HIV vary across its states and territories. Some areas explicitly regard transmission of HIV as criminal, while others prosecute conduct associated with HIV transmission under more general laws. Most of these non-HIV-specific laws only apply to individuals who have intentionally or recklessly transmitted HIV, and usually result in prison sentences. In addition, some areas require HIV-positive individuals to take “reasonable” measures to prevent transmission of HIV, or face fines.⁹ Unlike U.S. jurisdictions, Australia’s state and territorial governments have not used criminal laws to prosecute cases of HIV exposure without transmission.¹⁰

Although many countries have adopted HIV-specific criminal laws, guidelines pub-

lished by the Joint United Nations Global Programme on HIV/AIDS (UNAIDS) suggest countries move cautiously in this area. In addition to recommending the review of all laws that criminalize sexual activity (sodomy, fornication, adultery, or commercial sex work), the guidelines suggest that jurisdictions use general criminal laws, rather than HIV-specific ones, to cover the intentional transmission of HIV. The guidelines highlight the risk that vulnerable populations may be targeted by HIV-specific laws, exposing them to additional stigma and harm. Moreover, they emphasize that restrictions on liberty, including imprisonment, should be reserved for the rare cases involving deliberate and dangerous behavior.¹¹

The World Health Organization’s recent “technical consultation” takes an even stronger stand. It concludes that criminal laws run the risk of interfering with public health measures and messages, do not reduce the spread of HIV, threaten basic human rights, and should be used as a last resort.¹²

Conclusion

Legislatures in the United States and throughout the world have adopted criminal laws as one tool in their efforts to reduce the spread of HIV. From a public health perspective, the efficacy of these laws remains highly suspect. Although in the United States HIV exposure and transmission laws are rarely enforced, some courts have upheld lengthy sentences for violators. In some such cases, no HIV transmission occurred and the behavior the HIV-positive person engaged in posed little or no risk of transmission. Further, since these laws do not always support accepted public health messages, they can contribute to the stigma of HIV infection, and they contradict the recommendations of many public health organizations.

Authors

Zita Lazzarini is Associate Professor at the University of Connecticut Medical School, and director of the Division of Medical Humanities, Health Law and Ethics there. Her current research focuses on the impact of law, policy, and practice on health.

Ross K. Friedberg is a student in the joint JD/MPH program at the University of Connecticut. He has expertise in genetics and environmental law and is a staff member of the Connecticut Insurance Law Journal.

Some of the research described in this article (which does not represent the official views of the CDC) was supported by CDC Grant/Cooperative Agreement Number RO6/CCR118660-01. The authors acknowledge the wonderful help and support of Sarah Bray, Joe Bursleson, Matt Cook, and David Gregorio.

Clearinghouse: HIV and Criminal Law

References

Appel JM. Must my doctor tell my partner? Rethinking confidentiality in the HIV era. *Medicine and Health, Rhode Island*. 2006; 89(6): 223–224.

Betteridge G. Report documents criminalization of HIV exposure and transmission in Europe. *HIV/AIDS Policy and Law Review*. 2005; 10(3): 26–27.

Chalmers J. Criminalization of HIV transmission: Can doctors be liable for the onward transmission of HIV? *International Journal of STD*

and AIDS. 2004; 15(12): 782–787.

Chalmers J. The criminalization of HIV transmission. *Sexually Transmitted Infections*. 2002; 78(6): 448–451.

Chan J. Criminal law and HIV transmission or exposure: 10 new cases. *HIV/AIDS Policy and Law Review*. 2006; 11(2–3): 45–48.

Dhai A. The Criminal Law (Sexual Offences) Amendment Bill—implications of criminalising non-disclosure of HIV status. *South African Medical Journal*. 2006; 96(4): 301–302.

Franklin T. UK: First woman sentenced for infecting sexual partner with HIV. *HIV/AIDS Policy and Law Review*. 2005; 10(3): 46–47.

Franklin T. UK: Leave to appeal grievous bodily harm conviction and sentence denied. *HIV/AIDS Policy and Law Review*. 2005; 10(3): 47.

Herbert PB. Psychotherapy as law enforcement. *Journal of the American Academy of Psychiatry and the Law*. 2004; 32(1): 91–95.

Kipnis K. A defense of unqualified medical confidentiality. *American Journal of Bioethics*. 2006; 6(2): 7–18.

Klein A. U.S.: Sexual history must be

Tarasoff and HIV: Some Considerations for Therapists

Tiffany Chenneville, PhD

In the more than 30 years since Tarasoff, U.S. states have responded to the ruling in a variety of ways—in part because there is no unifying federal law.

For more than 30 years, questions about therapists' "duty to warn" and "duty to protect" have sparked controversy. Resolving the conflict between the two relevant mandates—the duty to maintain the client's confidentiality and the duty to protect others from harm—continues to create legal confusion, and, as a result, confusion among clinicians. While there is no easy solution and, some have argued, "no true professional standard,"¹ it is possible to make ethically sound, legally defensible decisions regarding this issue by considering the factors and taking the steps discussed below.

Tarasoff and Duties to Protect and to Warn

In 1969, Prosenjit Poddar, a student at the University of California, Berkeley, murdered a fellow student, Tatiana Tarasoff, two months after having made threats to do so to a counseling center psychologist. The victim's parents sued the university, claiming they or their daughter should have been warned of the threats. In 1976, the California Supreme Court ruled in *Tarasoff v. Regents of the University of California* that

clinicians have a duty to "protect" unknowing victims from potential harm. In this case, the court sided with the victim's father, who argued that the fact that the psychologist reported the threat to campus police officials was insufficient to protect their daughter, and that the victim herself or her parents should have been warned.²

In the more than 30 years since *Tarasoff*, U.S. states have responded in varying ways to the ruling—in part because there is no unifying federal law. As of 2002, 13 states had not addressed the "duty to warn" at all.³ Some state laws make breaches of confidentiality to protect others discretionary—they allow but do not require the therapist to break privilege.³ Most states have adopted some statutes that require some variation of the *Tarasoff* duty to protect but not necessarily the duty to warn.⁴ Generally, states follow one of three approaches: a mandated duty to warn the endangered party; a duty to protect, but not warn the endangered party (for example, the clinician may seek civil commitment for the client or report the threat to law enforcement officials); or a unified duty to protect and to warn as outlined in *Tarasoff*.

Like the courts, clinical professional associations have responded to the "duty to protect" and "duty to warn" mandates in a variety of ways. For example, the American Medical Association and American Psychiatric Association support taking steps to inform unknowing partners of possible HIV transmission as long as doctors have first disclosed the limits of confidentiality to clients.¹ The American Psychological Association, on the other hand, opposes the legal duty to warn and has been very specific in outlining the limited situations warranting a breach of confidentiality.^{1,5}

disclosed in lawsuit for negligent HIV transmission, California Supreme Court rules. *HIV/AIDS Policy and Law Review*. 2006; 11(2-3): 52–53.

Lowbury R, Kinghorn GR. Criminal prosecution for HIV transmission. *BMJ*. 2006; 333(7570): 666–667.

Roberts C. Case against prosecution. *Nursing Standard*. 2006; 20(46): 32–33.

Scarano VR, Baily CM, Banfield JR. The Texas Supreme Court speaks: Mental health professionals have no duty to warn or protect third parties. *Texas Medicine*. 2002; 98(11): 61–64.

Sirinskiene A, Juskevicius J, Naberkovas A. Confidentiality and duty to warn the

third parties in HIV/AIDS context. *Medical Ethics and Bioethics*. 2005; 12(1): 2–7.

Weait M, Azad Y. The criminalization of HIV transmission in England and Wales: Questions of law and policy. *HIV/AIDS Policy and Law Review*. 2005; 10(2): 5–12.

Wells J. Australia: Supreme Court of Western Australia orders retrial in case of man convicted of infecting girlfriend with HIV. *Canadian HIV/AIDS Policy and Law Review*. 2004; 9(2): 63–64.

Wells J. UK: Court of Appeal orders retrial in UK's first HIV criminal transmission case. *Canadian HIV/AIDS Policy and Law Review*. 2004; 9(2): 62–63.

Contacts

Zita Lazzarini, JD, MPH, Division of Medical Humanities, Health Law and Ethics, University of Connecticut Health Center, 263 Farmington Ave. MC-6325, Farmington, CT 06030-6325, 860-679-5494 (phone), lazzarini@nso.uchc.edu (e-mail).

Tiffany Chenneville, PhD, Department of Psychology, University of South Florida St. Petersburg, 140 7th Avenue South, DAV 258, St. Petersburg, Florida 33701, 727-873-4585 (phone), chennev@stpt.usf.edu (e-mail).

See also references cited in articles in this issue.

Problems Applying Tarasoff to HIV

The evolving nature of the law around the duty to protect and the duty to warn, and the variation in states' acceptance and interpretations of these duties can complicate therapists' understanding of appropriate versus inappropriate breaches of confidentiality in even the most classic *Tarasoff* cases (those that involve a threat of serious physical violence to another). Since the onset of the HIV epidemic, some therapists have wondered if these duties could also apply to cases involving potential HIV transmission. For example, what of the case in which a clinician learns that an HIV-positive client has not revealed his or her HIV status to a sexual partner?

If "traditional" *Tarasoff* situations involving threats of violence create ethical and legal dilemmas for therapists, the question of a therapist's responsibility to protect unknowing sexual partners from potential HIV infection is much murkier. While some courts have applied the duty to warn to cases involving HIV, these cases have typically not involved the therapist-client relationship, and have varied tremendously in both the facts and outcomes of the cases, making it difficult to draw clear legal conclusions. Some cases involving health care organizations or providers have been resolved in favor of maintaining confidentiality, while other courts have ruled in favor of breaching it for the purpose of protecting third parties. For *Tarasoff* to apply, it is critical that a foreseeable harm to an identifiable victim exist—a standard that is especially difficult to apply to HIV-related cases.

There are several other distinctions between "traditional" *Tarasoff* cases and those involving HIV. First, the danger of HIV transmission and the timing of that danger is unclear because transmission risk is based on medical probabilities, and the assessment of these probabilities could fall outside the clinician's scope of practice. Even if the determination of dangerousness is considered a behavioral, rather than a medical judgment, such predictions are both difficult and uncertain.

Second, because the potential danger is unclear, the sense of urgency is often lower in HIV-related cases, allowing a longer time frame in which the partner might be warned. This usually allows for the option of the client's self-disclosure to the partner, thus preserving the client-therapist bond of confidentiality while still warning the partner.

Third, in some cases, transmission may already have occurred, in which case

"protection" (if necessary at all, since the "danger" of transmission is past) is focused on affording the partner the right to be tested and treated, which can often be accomplished through partner notification services. Finally, in most cases, consensual sex implies a shared responsibility for communication and negotiation, which may relieve the client (and his or her therapist) of sole responsibility for the possibility of HIV transmission.

Considerations to Guide Decision Making

Are a client's actions likely to pose such a strong danger of HIV transmission to an unknowing third person that a breach of therapeutic confidentiality is justified? Therapists can approach this question by considering several factors. These include: the applicable mandates governing the provider's profession; the foreseeability of harm; the identifiability of the victim; and whether viable alternatives to warning the potential victim exist.⁶

Legal, Ethical, and Regulatory Mandates. Since laws vary so widely from state to state, and can change suddenly, it is critical for clinicians to understand how the laws of their own states apply to them. Similarly, an awareness of the professional standards and ethics that govern the therapist's practice is helpful, although in some situations state law and professional guidelines may conflict. Finally, some organizations have their own regulations regarding acceptable breaches of confidentiality for staff in different roles, and it is crucial for employees to seek supervision about their agencies' policies. The more clinicians know about each of these three sets of mandates, the better they can understand their professional responsibilities in a given situation.

Foreseeability of Harm. Several factors may influence whether it is likely that a sexual activity will result in HIV transmission to an unknowing partner. The type of the sexual activity (oral sex versus anal

References

1. Huprich SK, Fuller KM, Schneider RB. *Divergent ethical perspectives on the duty-to-warn principle with HIV patients.* *Ethics and Behavior.* 2003; 13(3): 263–278.
2. *Tarasoff v. Regents of the University of California*, 17 Cal.3d 425, 551 P.2d 334 (1976).
3. Herbert PB, Young KA. *Tarasoff at twenty-five.* *Journal of the American Academy of Psychiatry and the Law.* 2002; 30(2): 275–281.
4. Ginsberg BD. *Therapists behaving badly: Why the Tarasoff duty is not always economically efficient.* *Willamette Law Review.* 2007; 43(1): 31–68.
5. Palma TV, Iannelli RJ. *Therapeutic reactivity to confidentiality with HIV positive clients: Bias or epidemiology?* *Ethics and Behavior.* 2002; 12(4): 353–370.

Comments and Submissions

We invite readers to send letters responding to articles published in *FOCUS* or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals. Send correspondence to rob.marks@ucsf.edu or to Editor, *FOCUS*, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.

or vaginal sex), whether or not the partners use protection, and how frequently the partners have sex all relate to potential danger (although clearly HIV transmission could occur in a single sexual encounter). The questions of intention and imminence also may influence decisions about how dangerous the client is to the unknowing partner: does the client have an intention to harm a third party, and HIV is merely the means to do so? A client with a malicious intent represents a far different situation clinically (and, perhaps, legally) than a client who is simply unsure how to tell his or her partner. In such very rare cases where there is a clear intention to harm others, civil commitment may be an appropriate alternative. When is the next time the partner is likely to be at risk? And how strongly opposed to disclosure is the client? Is the client willing to consider any risk reduction measures?

Identifiability of the Victim. Is the identity of the client's partner or partners known to the clinician? Attempting to discover the identity of unknowing partners is usually considered to be outside the clinician's role. For example, if a client reports exclusively anonymous sex, potential victims are not identifiable.

In the case of couple's counseling, of course, the partner's identity is known to the therapist. This may present the most difficult situation for clinicians, because the therapist has a duty to the unknowing partner not only as a potential victim but also as a client, and because one of the main objectives of couple's counseling is to facilitate honest communication.

Alternatives to Warning. If a clear risk of HIV transmission exists to an unknowing, identifiable, HIV-negative partner, in a state in which the clinician is bound by a "duty to protect," the clinician can and should investigate whether such a duty might be discharged in ways other than breaking confidentiality. It is nearly always preferable for clients to disclose their own HIV status to partners themselves than to have a therapist disclose without client consent. Clinicians can explore clients' willingness to work toward telling partners—either by themselves or with the coaching or actual assistance of the clini-

cian. Clients who choose to disclose in the clinician's presence offer the added benefit of certainty that the disclosure has taken place. When clients do not feel able to disclose immediately, therapists can

help them explore other ways to effectively reduce risk prior to disclosure, including abstinence, using condoms, or switching from anal or vaginal sex to oral sex. Clinicians also can investigate whether partner notification services, if available, would sufficiently discharge their duty to warn current partners.

Steps for Clinicians

Clinicians can reduce the risk of harm to others while preserving the integrity of the therapeutic relationship by taking key steps:

Explain the Limits of Confidentiality

Early. Inform clients of the scope and limits of confidentiality at the outset of the relationship. This includes discussing its boundaries in individual therapy, as well as whether secrets of one partner will be held from another by the therapist in couples counseling. Clearly note any mandated reporting responsibilities (for example: child or elder abuse reporting, suicidality, and what will happen "if I hear that you are planning to do something that may physically harm someone else"). Such a discussion sets clear expectations that allow the client to decide what to share in therapy, and allow the therapist to refer back to the discussion if an issue of necessary breach of confidentiality ever arises.

Work as Part of a Team. In many settings, clinicians work as part of a multidisciplinary team with physicians and other providers. Even solo practitioners would be well-advised to obtain their clients' consent to consult with members of their clients' health care teams. This can allow clinicians access to more information about whether or not a foreseeable danger exists, and whether it can be addressed in ways other than warning. If warning is necessary, it may be more appropriate for the physician (who, in some capacities, may have more latitude to break confidentiality for this purpose in some states, such as California) to make the disclosure.

Work with the Client and Document These Attempts. Discuss with the client

Clinicians can reduce the risk of harm to others while preserving the therapeutic relationship by taking key steps.

6. Chenneville T. HIV, confidentiality, and duty to protect: A decision-making model. *Professional Psychology: Research and Practice*. 2000; 31(6): 661-670.

7. AIDS Law of Louisiana, Incorporated. Confidentiality versus the Duty to Warn: Guidelines for Social Workers. *New Orleans: AIDS Law*, 2002; <http://www.aidslaw.org/confident.pdf>.

Author

Tiffany Chenneville, PhD is Assistant Professor of Psychology at the University of South Florida (USF) St. Petersburg. She has a joint appointment with the Department of Pediatrics where she serves as the Director of Behavioral Health for the USF Pediatric/Adolescent Infectious Disease Program.



**Executive Editor; Director,
AIDS Health Project**
James W. Dilley, MD

Editor
Robert Marks

Clinical Editor
Michelle Cataldo, LCSW

Recent Reports
Alisa Bredo

Founding Editor
Michael Helquist

Medical Advisors
Stephen Follansbee, MD
George Harrison, MD

Design
Saul Rosenfield

Production
Erica Lyons
Lisa Roth
Lawrence Sanfilippo

Circulation
Lowanna Hopkins
Jennifer Regan
Victoria Toussaint

FOCUS, now published quarterly, is a publication of the AIDS Health Project, affiliated with the University of California San Francisco.

Receive the publication for free, via e-mail. Register online at http://ucsf-ahp.org/epubs_registration.php

For more information about how to receive *FOCUS* and a list of **back issues** and information, write to the above address, call (415) 476-2626, or e-mail michelle.cataldo@ucsf.edu.

Printed on recycled paper.

©2007 UC Regents:
All rights reserved.

ISSN 1047-0719



the benefits and importance of both risk reduction and disclosure, and document these interactions. In the unlikely case that warning is warranted, clinicians can prove that they attempted to take other steps short of warning that proved insufficient. If the clinician does not warn, and is sued by an unknowing partner, he or she can demonstrate that substantial steps were taken to protect the partner.⁷

Conclusion

Confusion about the confidentiality versus duty to protect dilemma persists despite the fact that more than 30 years have passed since the *Tarasoff* ruling. The complexity of defining danger in the context of HIV and of sexual behavior makes

the HIV-related application of the duty to protect particularly confusing. It is rare that a situation meets all the necessary criteria to require warning: In the majority of cases, the most appropriate plan is for clinicians to focus on helping clients overcome barriers to self-disclosure and, if necessary, to assist with the self-disclosure process.

While there are no easy solutions, clinicians should attempt to apply a formal decision-making process that includes the types of considerations noted herein when faced with this dilemma. Finally, as stated above, the importance of seeking qualified consultation regarding state law, professional ethics, and employer policies cannot be overemphasized.

Recent Reports

Criminalization of HIV Transmission in the UK

Dodds C and Keogh P. Criminal prosecutions for HIV transmission: People living with HIV respond. *International Journal of STD and AIDS*. 2006; 17: 315–318. (University of Portsmouth, U.K.)

Both of the articles in this issue explore the questions about responsibility for the disclosure of HIV-positive status. The British study below examines this question and others from the perspectives of people living with HIV. The following summary was adapted from the cited article and its abstract:

A study of HIV-positive people in England and Wales found that the criminal prosecution of individuals with HIV for “reckless HIV transmission” has caused concern and criticism among HIV-positive “African” heterosexuals and gay and bisexual men living there.

Researchers recruited and paid 125 HIV-positive participants from nonclinical community sources and conducted focus groups in London, Brighton, and Manchester.

From the 188 comments or exchanges, 12 themes emerged. The topics most often discussed were “shared responsibility,” the idea that, in consensual sex, HIV prevention is not solely the responsibility of the HIV-positive partner; and “increased stigma,” the idea that criminalization leads to societal blame and stigmatization. The single issue most often raised was that criminalization has weakened the public health message that each partner should be responsible for his or her

health. Overall, 90 percent of the study participants’ comments were critical of criminalizing reckless transmission of HIV. Notably, only 3 percent of comments related to fears that criminalization would lead to fewer individuals testing for HIV.

Next Issue

The next issue of *FOCUS* marks our transition to a quarterly newsletter. This Summer edition of *FOCUS* will also be the first available solely online. To ensure that you continue to receive *FOCUS*, please visit our website at http://www.ucsf-ahp.org/epubs_registration.php and give us your e-mail address.

Circumcision is receiving unprecedented attention as an HIV prevention method. In our next issue, **Adamson Muula, MBBS, MPH**, a physician and lecturer at the University of Malawi, and PhD candidate at the University of North Carolina at Chapel Hill discusses the potential of circumcision to prevent HIV acquisition and transmission in the developing world as well as applications to other areas.

Also in the Summer issue, **Andrew Grulich, MBBS, PhD**, head of the Epidemiology and Prevention Program at the University of New South Wales, and **David Templeton, MBBS**, a sexual health physician practicing in Sydney, Australia, explore what we know about the utility of circumcision as a prevention approach in resource-rich countries.

Don't Miss an Issue!

FOCUS is now Digital, Free, and Quarterly!

This is our final printed issue. Our next issue, Summer 2007, will be published electronically in August.

To make sure you keep getting *FOCUS* (which is now available FREE!), send us your e-mail address. Each quarter we will send you a digital (PDF) file.

To sign up, go to our online registration form at:

http://www.ucsf-ahp.org/epubs_registration.php

QUESTIONS? COMMENTS? IDEAS?

Please contact Michelle Cataldo LCSW, Clinical Editor at 415-476-2626 or michelle.cataldo@ucsf.edu.



FOCUS
A Guide to AIDS Research and Counseling
AIDS HEALTH PROJECT
May 2007 #22 #5

Sex, Crimes, and HIV Zita Lazzarini, JD, MPH, Ross K. Friedberg, JD/MPH cand.

In 2002, South Dakota authorities arrested and charged a popular college student and basketball star with multiple counts of 'knowing exposure to HIV,' for having unprotected sex with his girlfriend and at least two other students after having tested HIV-positive. He was the first person in South Dakota to face such charges under a law that makes this a felony.¹ Such cases pose the question: When is it a crime for a person with HIV to have sex? The answer is it depends—on what state that person lives in, how the state courts interpret that state's laws, and how prosecutors enforce the laws.² In most states, it is legal for a person with HIV to have sex if that person discloses his or her HIV status to a partner before having sex and the partner consents to engage in sex knowing that the individual is HIV-positive. Most states' laws do not clearly make condom use an alternative to disclosure and consent. In at least one state, Maryland, neither condom use nor disclosure is adequate protection against possible prosecution.³ In all states, however, these laws are range of U.S. state laws on this topic, briefly describes other countries' laws, and explores how the trend of criminalizing HIV exposure and transmission has affected people with HIV and HIV prevention efforts.

Laws Criminalizing HIV Exposure
Long before the appearance of HIV, U.S. states established laws criminalizing activities that were likely to expose individuals to infectious diseases such as yellow fever, smallpox, and tuberculosis. As recently as 2002, at least half of the states had such communicable disease laws (which typically imposed misdemeanor penalties) on their books.

During the late 1980s and the 1990s, approximately half of state legislatures adopted HIV-specific laws that criminalized a range of behaviors related to HIV. Scholars have suggested that many of these laws were passed in haste and in a climate of fear.⁴ These fears were partly due to the unique characteristics of HIV; unlike many other communicable diseases, HIV is incurable and, at the time many of these laws were passed, it was also the widespread misperception that HIV could be easily transmitted through casual contact. Moreover, nearly all these state laws punished violations as felonies. As of 2002, 24 states had passed criminal statutes that directly prohibited behavior associated with potential exposure to HIV. Examples of HIV-specific laws include laws that prohibit individuals with HIV from sharing injection equipment, donating blood or organs, having sex without disclosure to partners, and spitting, biting, or throwing or smearing blood, feces, or other body fluids. All except three states (Maryland, Kansas, and Washington) make some exceptions, permitting if the HIV-positive person gains consent from a partner or uses a condom. Fifteen states have also modified existing criminal statutes related to other crimes, such as rape and prostitution, with provisions that impose additional penalties on perpetrators who exposed others to HIV in the course of committing another crime.⁵ Overall, the HIV-specific statutes that apply to sexual exposure diverge from accepted public health messages in several ways. First, they focus on disclosure as the primary means of disclosing safer sex practices, including condom use. Second, most statutes make no distinction between higher-risk activities (for example, unprotected anal sex with an HIV-positive insertive partner) and lower-risk activities (for example, oral sex with

References

1. Fountain J. After arrest, campus queues for HIV tests. *New York Times*, May 1, 2002.
2. Lazzarini Z. *Bray*: the impact of criminal law on HIV risk behavior. *Journal of Law, Medicine and Ethics*, 2002; 30(2): 239-253.
3. Gailly C, Pinkerton S. Conflicting messages: How criminal HIV disclosure laws undermine public health efforts to control the spread of HIV. *AIDS Behavior*, 2006; 10(3): 451-461.