BHIVA Position Statement on HIV, the law and the work of the clinical team

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Introduction

Criminalisation for non-intentional transmission remains a complicated and contentious subject in the UK. The United Nations is clear that criminalisation in this context is unhelpful, and does not result in the desired effect of decreasing infection rates. It is disappointing in 2022 that prosecution remains possible in the UK.

The purpose of this statement is to outline issues at the interface between HIV transmission and the law and provide guidance to healthcare professionals (HCPs) working in the field of HIV Medicine. The guidance is to support work in the UK, and it is important to note that the law in England and Wales differs from that in Scotland and Northern Ireland. Approaches are suggested to deal with these issues consistently, within legal and General Medical Council (GMC) regulatory frameworks and in the context of the public health agenda. The guidance specifically addresses sexual transmission.

Our previous statement on this subject was published in 2013 [1]. At the time of the 2013 statement, the evidence around transmission related to suppressed viraemia was just beginning to accumulate in favour of supporting the Swiss statement of 2008 [2]. Now, in 2022, it is clear that a suppressed viral load (less than 200 copies/mL in the PARTNER study [3], but widely accepted in the UK as less than 50 copies/mL) means that HIV cannot be transmitted to a sexual partner. This is commonly referred to as undetectable=untransmittable, or U=U.

It remains BHIVA's position that the use of criminal law in relation to HIV transmission does not contribute to public health aims of reducing the number of new infections or reducing stigma. This position is consistent with international recommendations including those of the Global Commission on HIV and the Law [4] and the United Nations Development Programme and the Joint United Nations Programme on HIV/AIDS (UNAIDS) [5,6]. BHIVA's position is further supported by the 2018 expert consensus statement on the science of HIV in the context of criminal law [7].

This position statement is scheduled for review by 2027.

Criminalisation of HIV transmission

HIV criminalisation describes the application of criminal law to people living with HIV based on their HIV status. Globally at least 130 countries have criminal laws that can be, or have been, applied to allegations of HIV transmission, HIV exposure and non-disclosure of HIV status [8]. Criminalisation includes the investigation, prosecution and conviction of people for transmitting or exposing others to HIV.

The UK has three legal systems (jurisdictions) within its boundaries, covering the four devolved administrations (England and Wales has a shared legal system, and Scotland and Northern Ireland each have separate systems). The broad approach is the same in that all have provision to criminalise sexual transmission of HIV, using the mechanisms of their particular legal system. England and Wales and Northern Ireland have the least restrictive systems as there is no possibility of prosecuting for reckless exposure (where someone is exposed to the risk of transmission but where transmission does not take place). Prosecution is possible in Scotland in instances where a person has been exposed to the risk of transmission but transmission has not in fact taken place, although legal guidance makes clear that this should only be used in exceptional circumstances [9].

For the purposes of this guidance, the focus will be on the issue of 'reckless transmission', which is common to all the jurisdictions. While regulatory frameworks continue to use the word 'disclosure', the preferred term for this document is 'sharing', when referring to the sharing of HIV status.

In England and Wales, only intentional or reckless transmission of HIV and deliberate (but unsuccessful) attempts to transmit are criminalised. The applicable law in HIV criminalisation cases is the Offences Against the Person Act 1861, which enables prosecution of intentional transmission under section 18, and reckless transmission under section 20 [10]. Deliberate attempts to infect are charged under the Criminal Attempts Act 1981 [11].

Intentional and reckless transmission of HIV

There has been one successful prosecution for intentional transmission of HIV. Since the case of *R v Dica* in 2004 [12], there have been 26 successful prosecutions for reckless transmission of HIV in England and Wales [13], under section 20 of the Offences Against the Person Act 1861. There have been many more investigations and charges.

For the offence of 'intentional' or 'reckless' transmission, the prosecution must establish all three of the following (Figure 1) [14]:

1. The infliction of harm or the requisite act, conduct or consequence (known as the *actus reus*).

This means proving that the individual (defendant) is the source of the infection. In other words, that the defendant transmitted HIV to the complainant. The evidence for this is collected through medical and sexual histories and may include the use of phylogenetic analysis[1].

2. The defendant intended the consequence (section 18) or acted recklessly (section 20) (known as the *mens rea*).

[1]Phylogenetic analysis involves the study of blood samples from the accused and the complainant to determine the genetic relatedness of their HIV strains. This cannot prove that HIV transmission occurred directly between the two parties, but it can exonerate individuals where it is shown that the accused carries a virus strain unrelated to that of the complainant. Where the accused and the complainant carry strains that are closely related, this would show that it is possible the accused transmitted HIV to the complainant but additional factual evidence would be required; phylogenetic evidence alone is insufficient.

For section 18 it must be proven that the defendant actively intended to transmit HIV to the partner.

For section 20, the act of recklessness has been defined as conscious risk taking: where a person knows that some harm may arise from their conduct, but they continue to take this risk (*R v G*) [15]. Therefore, the use of condoms or treatment as prevention (treatment where the primary aim is to prevent the transmission of HIV) would be likely to avert a finding of 'recklessness' in the unlikely event that transmission of HIV occurred under these circumstances.

The paramount consideration for section 20 is the individual's actual understanding around transmission. If they believe that once their viral load is undetectable that they cannot transmit HIV (and believe themselves to have an undetectable viral load), or that condoms make the risk of transmission negligible (both of which the Crown Prosecution Service acknowledges as appropriate safeguards), then the *mens rea* of recklessness is unlikely to be found.

The act of recklessness also requires that at the time of the alleged transmission the defendant knew they had HIV and understood how HIV is transmitted. This is usually evidenced by confirmation of a medical diagnosis and through clinical notes. There is also the potential for 'deliberate closing of the mind' to be considered. This is the circumstance under which someone who has not received a medical diagnosis could nonetheless know or strongly suspect that they have HIV through their own particular circumstances (such as having been advised to take an HIV test by an HCP because of concerning symptoms). Evidence of these circumstances may be sufficient for the court to decide that the defendant had the required degree of knowledge to have acted recklessly.

3. The absence of a valid defence.

In the case of reckless transmission (section 20), consent to sex (or condomless sex) is insufficient as a defence. Instead, it must be demonstrated that the complainant actively consented to the risk of HIV transmission, i.e. they made a 'conscious' decision to put themselves at risk of acquiring HIV *(R v Konzani*) [16]). This would require them to be informed of the defendant's HIV status, either directly or indirectly, prior to the alleged occurrence of transmission. There is no legal requirement for a person to disclose their HIV status to sexual partners, but this appears to be the only means of securing a defence of consent where the court has found the requisite *mens rea* and *actus reus.*

For the crime of intentional transmission (section 18), consent to the risk of HIV acquisition on the part of the partner is not a valid defence.

The Crown Prosecution Service has provided guidance regarding what may and may not be mitigating factors in considering whether a decision to prosecute would be in the public interest [17].

Attempting to intentionally transmit HIV

It is also possible to be prosecuted for *attempting* to intentionally transmit a serious sexually transmissable infection under the Criminal Attempts Act 1981. This requires the prosecution to prove that it was the defendant's intention to transmit HIV, but does not require transmission to have occurred.

The question of the known presence of a sexually transmitted infection cancelling out the consent to sex (and therefore causing consideration of rape) sometimes arises. This has been clearly addressed in law, in that a person who does not disclose the fact that they have a sexually transmitted infection and then has consensual sexual intercourse with another, without informing that person of their infectious state, is not guilty of rape [18].

The impact of HIV criminalisation

The courts appear to place the burden of reducing HIV transmission on the person living with HIV. This approach is inconsistent with public health initiatives aimed at reducing HIV transmission, such as pre-exposure prophylaxis (PrEP), which promote and enable individual responsibility within the HIV-negative population. As a result, it is considered by BHIVA that prosecution for reckless transmission promotes stigma and may be counterproductive with regard to public health aims. It has also been shown that prosecution for reckless transmission is associated with harms [19].

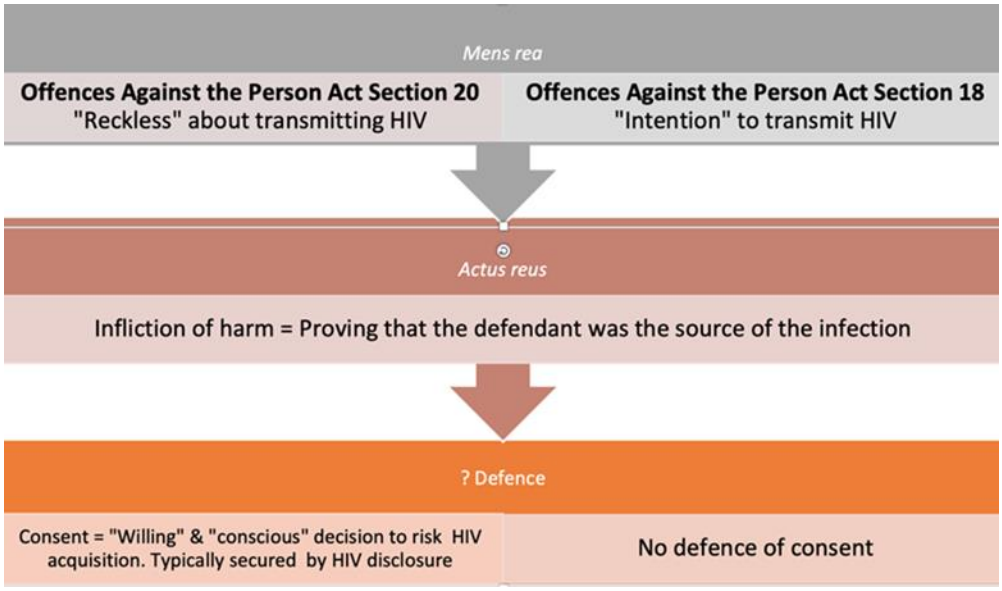

Figure 1. Offences Against the Persons Act 1861 and HIV transmission.
Reproduced from Saigal P, Weait M, Poulton M. *Sex Transm Infect* 2018; **94**: 399–400 [14] with permission from BMJ Publishing Group Ltd.

Criminalisation of HIV in the clinical setting

It is worth highlighting that when confronted with a situation in clinic in which this position statement may be accessed, there is often a sense of urgency to reach a conclusion. Such a situation can include the presence of police officers in clinic. There are no situations in which a decision cannot wait for due process, i.e. review at a multidisciplinary team meeting and by appropriate individuals/teams.

Strategies to reduce the risk of prosecution for reckless transmission

Despite the majority of people living with HIV in the UK being virally suppressed, people living with HIV remain at risk of allegations of criminal transmission, and sometimes prosecution. People at particular risk include:

- Individuals who have recently been diagnosed with HIV but who have either not yet started treatment or who do not yet have an undetectable viral load;

- Individuals who choose not to use antiretroviral therapy (ART);
- Individuals who decline HIV testing, but have been told they are at high risk of being HIV positive, e.g. this might apply if someone has been advised to test for HIV through partner notification;
- Individuals who do not have an undetectable viral load despite taking adequate treatment;
- Individuals who experience barriers to accessing ART or to treatment adherence. Barriers may be completely out of the control of the individual (such as access to ART in detention centres);
- Adolescents and young adults living with HIV who engage in sexual activities/relationships.

Alternative measures to reduce the risk of HIV transmission must be considered in these circumstances, including the use of condoms with water-based lubricant. In the event of a split condom, disclosing HIV status to their sexual partner to facilitate post-exposure prophylaxis (PEPSE) would reduce the risk of HIV transmission. In addition, PrEP is now available throughout the UK, and so a person at risk of acquiring HIV can consider taking this to mitigate the risk of HIV acquisition. It is recognised that there are populations that are underserved with regard to supported access to PrEP, and there is further work to be done to ensure equitable access for all those in need of PrEP.

For those choosing not to take ART, their choice should be respected and explored carefully to ensure that the risks and benefits of this option are understood in terms of their health and public health implications. There are a number of strategies that may help individuals in this situation including peer mentorship, support from a specialist pharmacist or a psychologist, adherence support and education to ensure all options for a tolerable drug regimen have been explored.

Adolescents and young adults may experience a range of additional needs that are different from those of adults. For young people requiring support around HIV knowledge sharing and sex, we recommend referring to guidance from the Children's HIV Association.

Sharing information about legal issues with a person living with HIV

Informing patients about potential criminal culpability is arguably part of our professional clinical duty. A person who is newly diagnosed with HIV needs an understanding of the legal risks around transmission of HIV in order to be able to protect themselves from liability. This information is likely to be of less relevance for someone who becomes fully suppressed on successful ART. Information should be shared sensitively and supportively. This aligns with the public health agenda of preventing further infections [20]. It may be stated that:

- People have been convicted of transmitting HIV in the UK and of intentionally attempting to transmit HIV.
- The steps that can be taken to reduce or eliminate the risk of transmission (consistent use of condoms, adherence to effective ART or ensuring that sexual partners are taking PrEP) also minimise the risk of being found criminally liable in the context of reckless transmission.
- We suggest that sharing knowledge of a diagnosis of HIV is the best way to enable shared decision-making. Sharing knowledge of HIV status with partners will serve to protect people living with HIV from criminal liability for reckless transmission, if sharing the knowledge

results in consent to the risk of HIV acquisition. This decision should be made on an individual basis, recognising the reasons some people choose not to share their status and accounting for the actual risk of transmitting HIV (which does not exist if someone fulfils the U=U criterion).

- Being undetectable means a person cannot transmit HIV, therefore they cannot be liable for transmission in England, Wales and Northern Ireland. (While prosecution for exposure is possible in Scotland, the Crown Office has issued guidance stating that where a person is on treatment it is unlikely that it will be possible to establish criminal recklessness, and that there is a very strong presumption against prosecution in such circumstances [9].)
- Expert resources exist (such as from National AIDS Trust [NAT], Terrence Higgins Trust [THT] and George House Trust [13,21,22]) to help someone who has been accused of transmitting HIV, and clinicians aware of individuals who require such help should strongly recommend these resources.

Confidentiality and information sharing for HCPs

HCPs can feel concerned that they are aware of someone's HIV status when a sexual partner is uninformed. Once a person is on ART and has an undetectable viral load, there is no ongoing risk. The evidence base for U=U provides full reassurance that if someone's viral load is undetectable on ART, there is no need, in terms of legal responsibility or risk to the sexual partner, to disclose their status as they cannot transmit the virus. There may be benefits in discussing their status with a partner, such as the potential for support through shared knowledge and care.

Where there is retrospective risk, or a patient continues to have a detectable viral load, GMC guidance stipulates that a doctor may disclose someone's potential to transmit HIV if they believe that an identifiable individual is at risk of serious harm and the patient cannot be persuaded to inform them [23]. Of note, there is no duty to disclose (hence the GMC's use of the word 'may'). Furthermore, a duty to justify any disclosure would fall on the clinician. The Irish courts examined the issue in 2018 (The Child and Family Agency v A.A. & Anor) [23] and reasoned that acquisition of HIV was not a serious enough harm to justify disclosure. Part of the reasoning centred on the fact that HIV is now a manageable chronic disease. Although in a different jurisdiction, and not a binding precedent in the UK, this case demonstrates how the view of the courts may evolve over time along with advances in medical care. Thus, the HCP must be confident that there is a risk of transmission and, in the case of ongoing risk, that the person living with HIV cannot be persuaded to inform their partner of their HIV status.

A person living with HIV may have a number of concerns about the sharing of this information such as fear of abandonment, stigma from family or community, potential for domestic violence or loss of control of their personal information. It is therefore of paramount importance that this issue is dealt with sympathetically and supportively and with regard to the safety and security of the individual. The issue should be reviewed in context, and should be seen as a process and not a singular event [25]. Preferably, a member of the team experienced in supporting individuals around information sharing of HIV status should lead on this. The member of the team should be familiar with and able to access the full range of strategies to provide testing without specific disclosure (such as anonymous partner notification or provider referral via Sexual Health clinics).

Only after all opportunities for support and guidance have been exhausted, and an HCP has genuine concerns that someone is at heightened risk of HIV acquisition, should information sharing by an

HCP be considered. Ultimately, HCPs should remember that the sharing of someone's HIV status is to encourage another person to test for HIV, something that the other person may choose not to do. Sharing does not guarantee a positive outcome.

If an HCP decides that in light of their circumstantial knowledge information sharing should be pursued, the case should first be discussed at an HIV multidisciplinary team meeting; it should not be a unilateral decision. If the decision is supported, the case should be discussed with the Caldicott Guardian who is responsible for confidentiality of patient identifiable information. The HCP should check that the Guardian has experience of advising on such cases; if they do not, they should be asked to contact BHIVA. Before proceeding with sharing, the HCP is advised to have discussed the case with their medical defence organisation. Again, the HCP should check that the advisor with whom they speak has experience in such cases as there have been occasions when advice has not acknowledged the nuances of this issue. As per the GMC guidance, the decision should then be shared with the person whose HIV status is going to be disclosed against their will, along with the justification. It would be good practice to follow this up in writing.

Request by another agency for an HCP to disclose HIV status

If someone has been accused of reckless or intentional transmission of HIV, there may be a request from the police for access to their medical records. There is no legal duty to comply with this without either the person's consent or a court order. Any request should follow local protocols. It is important to note that a police request does not need to be answered immediately, although there may be an impression that it should. A request should also evidence a legitimate need for the police to access the information requested, in line with legal and investigational advice relating to the criminal transmission of HIV [17].

Where possible, HCPs should ask the person about whom information has been requested for permission to share their information and obtain written consent. The person sharing this information should be reasonably assured that consent is not obtained under duress, such as while someone is in police custody. Ultimately, the police may apply for a court order. The court order must be complied with and will normally be dealt with by the legal team of a trust or hospital. Notes should be reviewed in advance to redact information with regard to any further identifiable individuals to avoid inadvertent disclosure of any information relating to others.

There have been cases in which requests have been made to share information around HIV where reckless or intentional transmission were not the alleged crimes under investigation. Such requests should not normally be complied with unless there is a court order. BHIVA, NAT and THT all have resources available to support decision-making in complex situations.

Summary

Fortunately, as a result of medical developments and the finding that U=U, the concern of reckless transmission is minimised for the majority of people living with HIV in the UK who maintain an undetectable viral load. However not all people living with HIV have an undetectable viral load and furthermore some may never have. ART is not universally easily available due to a number of barriers. Therefore a minority of individuals remain at risk of investigation and prosecution for reckless transmission of HIV.

UNAIDS urges states to use the law only in cases of intentional transmission; as noted above, BHIVA's position remains that application of the criminal law to cases other than intentional transmission may be counterproductive to public health aims.

Key agencies with expertise

British HIV Association:	www.bhiva.org
Children's HIV Association:	www.chiva.org.uk
George House Trust:	www.ght.org.uk
National AIDS Trust:	www.nat.org.uk
Terrence Higgins Trust:	www.tht.org.uk

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