



Abstract

This article highlights the ethically uncertain and emotionally charged climate that governs the criminalization of HIV nondisclosure in Canada. Focusing on AIDS Service Organizations (ASO), we suggest that interlocutors perform critical work that helps people living with HIV/AIDS make sense of their rights and responsibilities. Semi-structured interviews with 62 ASO staff across Canada revealed this shifting landscape of HIV advocacy in the age of criminalizing HIV nondisclosure. Drawing on a critical bioethics approach that is informed by considering the role of emotion in decision-making, this article critiques the liberal model of the rational actor that is central to traditional discussions of bioethics and law. Our findings suggest that ASO workers have varying degrees of knowledge about the intricacies of legal duties of disclosure, which affect how they balance their own emotions and thoughts about nondisclosure with their professional duties to provide support and counselling. Ultimately, we argue that critical bioethics in the context of criminalization commands us to appreciate the inherently affective nature of the environment in which bioethical decisions are made.

Key Words criminalization, HIV/AIDS nondisclosure, critical bioethics, emotion, medico-legal borderland

Critical bioethics in the time of epidemic: The case of the criminalization of HIV/AIDS nondisclosure in Canada

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Introduction

From calls for mandatory testing to imposing quarantine, HIV/AIDS has evoked intense ethical debate since its discovery in the early 1980s. During those early years, attention centered on groups that were vilified as moral threats to public health, namely sex workers, injection drug users, and gay men. While great strides have been made with respect to the scientific understanding of HIV/AIDS since that time, the ethical debates that engulf it are no less perplexing today.

Arguably, the criminalization of HIV/AIDS nondisclosure is one of the most ethically contentious issues to arise in recent years. The subject of lurid media coverage, efforts to punish HIV-positive individuals for exposing their sexual partners to HIV have been loudly denounced by activists and advocates, many of whom insist that criminalization increases stigma, frustrates public health efforts that encourage testing, and signals a regressive return to the moral panic climate of the early years of the AIDS epidemic.[1-5]

Expanding on the promising conceptual framework offered by critical bioethics,[6,7] we explore the *emotionally charged* and *ethically uncertain* climate of the criminalization of HIV nondisclosure in Canada. We suggest that a critical bioethics for HIV/AIDS must include considerations of “bioethics on the ground,” which Heimer conceives as the ways in which the “more inchoate moral sentiments of ethics on the ground get transformed into decisions and courses of action... These on-the-spot decisions about particular instances often cumulate over time into routinized but not fully codified ways of doing things”.[8 p374] By including considerations

of on-the-spot decisions, critical bioethics can better contemplate the emotional nature of bioethical decision-making, in contrast to the liberal approach that reproduces problematic assumptions about the so-called rational actor and views individuals as not “fully autonomous when ruled by emotions or bodily urges”.[7 p3] We argue that it is essential to consider the role of emotions in disclosure and in disclosure counselling and by extension, bioethical decision-making. In fact, one of the most important objectives of this article is to critique the conventional model of the rational actor that is normative in the fields of bioethics and law.

Showcasing how emotions give meaning, in her definitive cultural history of HIV/AIDS, Paula Treichler describes AIDS as both a “transmissible lethal disease and an epidemic of meanings or signification”.[9 p1] Evoking intensely divisive political, social, cultural and emotional responses, epidemics of signification reveal crises of meaning. In order to appreciate what HIV/AIDS means in our current age, Treichler suggests we need, “a comprehensive mapping and analysis of these multiple meanings... (T)hese may rest upon ‘facts,’ which in turn may rest upon [...] deeply entrenched cultural narratives...”.[9 p287] Criminalization may be understood as “an epidemic of signification” grafted onto the broader HIV/AIDS epidemic. While the epidemic language of urgency (e.g., Silence=Death) that animated the HIV/AIDS movement in North America in the 1980s has somewhat dissipated, criminalization carries with it a discursive force that reinscribes HIV/AIDS as a contemporary problem to be feared.

Debates about criminalization reinforce the exceptional nature of HIV/AIDS in industrialized contexts, despite the fact that it is increasingly framed as a chronic, manageable condition. Smith and Whiteside documented the history of AIDS exceptionalism and found that in developed countries HIV/AIDS is gradually being integrated into more general public health frameworks that address a range of blood-borne diseases.[10] We are interested in how this paradox of HIV/AIDS exceptionalism is related to efforts to promote tolerance and de-stigmatization amidst an ongoing discourse of HIV/AIDS rooted in fear, shame and disgust. We suggest that the meanings attached to HIV/AIDS are shifting in the wake of scientific advancements and legal judgments that together are creating an *ethically uncertain* climate. More specifically, we are interested in how criminalization is promoting the unanticipated expansion of bioethical concerns in the advocacy field. This discussion builds on existing research that identifies some of the similarly knotty ethical challenges public health nurses face in their HIV-

related work. For example, nurses have been found to employ varied strategies in trying to balance their duties to warn and protect. In some cases, they provide robust discussions of the limits of confidentiality, especially given the possibility that whatever their patients reveal during post-test counselling might be subject to subpoena in a court of law.[11,12] In other instances, however, they reason that it might be unnecessarily burdensome to inform their patients about the risks associated with disclosure in the course of counselling unless they are asked directly. As Sanders notes, this model “relies on clients to arrive prepared with questions about what statements can later harm them in a legal context. The expectation of a rational and informed mindset perhaps does not adequately acknowledge that some recently diagnosed HIV-positive clients present for counseling feeling distraught and unfocused as opposed to rational and level-headed”.[11 p258]

To set the stage for this discussion, we begin by reviewing some of the key court decisions that structure the criminalization debate in Canada, paying close attention to the ways they showcase the medical and juridical complexity that can foster bioethical uncertainty. This is followed by a brief description of the methodology and then a section that outlines the theoretical framework employed for this research. In the final section, we use empirical material to demonstrate how a critical bioethics framework can be enriched by considering the role of emotions in the articulation of bioethical decision-making, which challenges the traditional conception of the rational actor that informs the fields of both bioethics and law.

Medico-legal borderland and the creation of bioethical uncertainty

Timmermans and Gabe use the term “medico-legal borderland” to describe how medical and legal discourses, institutions, and powers intersect to constitute new forms of knowledge about particular identities and ways to govern and regulate them.[13] While criminalization occurs in a number of countries, including the U.S., the U.K. and New Zealand, it has been especially prominent in Canada. Approximately 180 individuals have been charged with HIV nondisclosure during a sexual encounter, with the province of Ontario representing nearly half of all cases.[14] From the landmark *Cuerrier* decision in 1998 to the jointly heard *D.C.* and *Mabior* cases in 2012, the Supreme Court of Canada (SCC) has grappled with the medico-legal borderland regarding the duty to disclose one’s HIV status to a sexual partner. *Cuerrier* set criteria for determining whether consent was fraudulently attained: the accused must have knowledge that they are

HIV positive and of how HIV/AIDS is transmitted and must either lie about or fail to disclose their sero-status; there must be a “significant risk of serious bodily harm” as a result of the accused’s dishonesty;[15 para.128] and the Crown must prove that the complainant would not have consented to sexual activity had they been aware the accused was HIV positive. Canadian lower courts struggled to interpret what constitutes significant risk,[3] leading to contradictory verdicts and juridical uncertainty. For example, *Edwards* was found not guilty of aggravated assault and sexual assault because the court did not consider oral sex as constituting a significant risk;[16] yet, other oral sex cases have led to guilty verdicts.[3] Adding to the climate of scientific uncertainty, *Trott* was found guilty when he had unprotected anal sex, despite the fact that he was the receiver or “bottom,” which carries a much lower risk of transmission than if he had been the “top” or insertive partner.[17]

In 2012, the SCC jointly heard submissions from *Mabior* and *D.C.* and ruled that significant risk of serious bodily harm should be read as “a realistic possibility of transmission of HIV”. [18 para.94] However, like *Cuerrier* before them, both of these cases pertained to penetrative vaginal sex only; the lower courts have yet to rule on the realistic possibility test for cases involving anal (higher risk of transmission) and oral sex (lower risk of transmission). The Court determined that the risk of transmission could be reduced so as to justify nondisclosure only when the HIV-positive individual carries a low or undetectable viral load (typically considered 50 copies or less of HIV per cubic ml of blood) and a condom is used, thereby setting an even more stringent requirement for disclosure than *Cuerrier*. The SCC’s inclusion of a low or undetectable viral load in its judgment illustrates how the medico-legal borderland adds another layer of bioethical uncertainty to the nondisclosure debate. The Court failed to consider for how long a particular viral load test should be considered legally valid, although it is common medical practice to test every three to four months when an individual is undergoing antiretroviral treatment (ART) until the viral load count has been suppressed to low or undetectable levels and every six months thereafter. Tests can be more frequent at the start of treatment or when there is a change in treatment. That said, some individuals receiving ART and who achieve long-term suppression of their viral load to undetectable levels may exhibit periodic, temporary viral load blips. Blips are small increases (between approximately 50 and 1000 copies/ml), that can last for up to three weeks, which means they are easy to miss on routine viral load testing. Currently, there are insufficient data to speculate on the magnitude of

transmission risk related to viral load blips.[19]

This brief survey of key Canadian cases demonstrates how the evolution of medico-legal knowledge has contributed to a climate of bioethical uncertainty for the HIV/AIDS community in Canada. The medical and legal questions raised by nondisclosure are far from clear-cut and while they may speak to traditional liberal principles central to bioethics such as autonomy, nonmaleficence and justice, they also underscore the need to account for the role of emotions in structuring the environment in which bioethical decisions are made.

Methodology

After receiving approval from our university’s Research Ethics Board, we conducted 62 semi-structured interviews with frontline workers in Canada’s ASO community. Interviews were conducted in two phases between early 2014 and the fall of 2015. To recruit potential interview candidates, we contacted the Executive Directors at ASOs across the country, who then forwarded our information sheet to staff. Using snowball sampling, we were able to increase the number and diversity of interviewees through networking. In-person interviews were conducted in all ten provinces and primarily took place in offices at ASOs or other work-related locations. On-site interviews allowed us to undertake observations of the similarities and differences among the various ASO environments, as well as to engage with community members and collect informational and educational materials that the ASOs offer to their clients.

The majority of participants can be categorized as frontline workers who support and advocate for people living with or at risk for acquiring HIV/AIDS. Participants also included the Executive Directors of some of the organizations, social workers, administrators, as well as nurses and doctors connected to ASOs and who work exclusively within the HIV/AIDS community. Slightly more women than men were interviewed (55% women versus 45% men), which reflects the fact that women more commonly work in the helping professions. The interviews were recorded digitally, transcribed verbatim, and then coded and analyzed using critical discourse analysis – a method that links discourse to broader social and political contexts and institutional systems.[20,21] The main limitation of this study is that we only interviewed ASO staff. While some participants self-identified as HIV positive – they volunteered this information as we chose not to ask individuals to share their serostatus – it would have strengthened our results to have interviewed PLWHA directly about their emotions toward disclosure and

criminalization. We endeavour to do so in the next phase of our research agenda. To be clear, however, the main objective of the study was to explore the increasing role that AIDS service organizations play in decision making vis-à-vis disclosure.

Theoretical framework: Toward a critical bioethics of the criminalization of HIV/AIDS nondisclosure

Critical bioethics can help us to analyze how the current climate of uncertainty in terms of medical, juridical, and bioethical knowledge is (re)shaping our understandings of HIV/AIDS and the collective commitments to curtail new transmissions. While bioethicists were slow to take seriously the ethics of infectious disease,[22,23] we suggest that Canada's experience with criminalization offers an opportunity to engage a more sustained debate about this changing ethical landscape vis-à-vis HIV/AIDS. Building on previous research that highlights the experiential knowledge of PLWHA,[1,3,24-27] we train our analytical lens on those interlocutors in the ASO community who assist individuals with questions about how to conduct themselves in this *emotionally charged* and *ethically uncertain* climate. As Heimer explains in her ethnographic study of HIV clinics, a "bioethics on the ground" is interested in the spaces in between what we officially know and understand about bioethics and what is experienced in the everyday.[8]

Criminalization is *emotionally charged* as nondisclosure cases typically lead to feelings of anger, fear, guilt, shame, and disgust.[2,26-27] Individuals charged with failing to disclose their status are often portrayed in the media as morally reprehensible, while their partners are cast as unwitting victims. Like many areas in the field of bioethics, the criminalization of HIV nondisclosure is *ethically uncertain* because legal and scientific knowledge about HIV transmission is constantly shifting, making it difficult and unclear for ASOs and PLWHA to determine what might constitute ethically and/or legally appropriate sexual conduct. Moreover, one might judge that it is immoral to withhold one's HIV positive status, yet simultaneously reject the notion that the act of nondisclosure itself should be criminalized. As noted, the field is also uncertain because the Supreme Court of Canada has ruled exclusively on cases involving vaginal sex. The evolving nature of knowledge about the risks associated with different forms of sexual activity means that complex legal questions and bioethical decisions occur in a vacuum within the medico-legal borderland. For example, should exposure to HIV be as ethically and legally proscribed as actual transmission? What if a condom is used and there is

no intent to transmit HIV?

We complement the critical bioethics framework with specific attention to the role of emotions and to its profoundly gendered context, which have received comparatively little attention in the bioethics literature.[28] To date, Canada's experience with the vexing ethical-legal issues related to the criminalization of HIV nondisclosure suggests the need to rethink the core concepts of autonomy, nonmaleficence, beneficence, and justice that traditionally underpin the field of bioethics. For example, we challenge the notions of beneficence and justice as they pertain to the criminalization of HIV nondisclosure, wherein most cases there is no willful intent to transmit HIV. The main benefit is an emotional one for victims who feel hurt or angry and desirous of punishment. There is no evidence that criminalization operates as a deterrent, but rather that it may instead hinder public health by encouraging people to avoid testing. [1,3-5] The risks at the individual and societal levels are disproportionate to the benefits when we consider that the accused faces a lengthy (and costly) period of time in prison should they be convicted. Moreover, while using a condom to protect one's sexual partner might fulfill the principle of nonmaleficence, not to mention demonstrating an ethic of care, this nonetheless fails to meet the rigid legal requirements imposed by the realistic possibility test. Finally, the notion of autonomy, or self-determination, needs to account for the complex decision-making environment faced by individuals who are legally required to disclose their HIV status. The idea of the "thoughtful chooser"[29] who can act on the basis of their individual preferences or interests masks the admittedly provisional, uncertain and imperfect knowledge upon which individuals must act.

As Battin et al. note in their critique of conventional bioethics, what typically gets left out of discussions that adopt the notion of the rational actor is the dualism of being both a victim and a vector of the disease.[29] Their victim-vector approach proposes the notion of the "way station self," a self who is both vulnerable to disease but also a potential threat to others. In its zeal to present both sides of the picture, however, the idea of patient as both victim and vector can reproduce some of the heavy-handed language that has characterized failed responses to public health concerns in the past. For example, identifying someone as a vector of disease, whether as 'Patient Zero' in the case of Quebec flight attendant Gaëtan Dugas or as an 'AIDS predator' in the criminological imaginary, does little to appreciate the troubled history that marginalized populations affected by HIV have experienced at the hands of well-meaning public

health experts. Moreover, a singular focus on victimhood in terms of vulnerability to disease neglects the reality that vulnerability to disease is structured by a host of factors beyond an individual's control. Feminist theorists such as Patricia Hill Collins rightly discuss the importance of paying attention to the intersectional "matrices of oppression." [30] This is a particularly important framework for considering the different situations of women in relationships that are potentially characterized by violence and who are justifiably concerned about disclosing to their sexual partners out of fear of violent reprisals.

To address these concerns, we adopt Hedgecoe's view that a critical bioethics must move beyond the traditional model of the individual rational actor that dominates the field. [6] While we do not discount the value of the core bioethics concepts or principles, we argue that constructions of the individual as an always-already rational actor who is solely responsible for exposure to and onward transmission of HIV, neglects the complex intersection of different actors and discourses in bioethical conversations around HIV. Moreover, this approach fails to consider the effects of the history of the HIV/AIDS response in North America, which has not been particularly kind to PLWHA; given this history, it is not surprising that individuals might find it difficult and even dangerous to openly disclose their HIV status. [2,26, 31]

Hedgecoe identified three potential elements in his articulation of a critical bioethics. First, he suggests that critical bioethics must be "theory challenging," specifically incorporating social science insights in ways that illuminate the social worlds of bioethics via "the sociological imagination". [32] Our respective training in criminology, law, public policy, and political science influences the perspective we advance here. The second feature of critical bioethics is reflexivity. Echoing Hill Collins, [30] Hedgecoe explains that, "who we are in terms of class, ethnicity, profession, religion, sexuality, education and experience of medical settings (how many times we have had surgery for example) shape our instinctive and intellectual responses to biomedical technologies". [6 p138] As applied to the criminalization of nondisclosure, reflexivity also involves attention to how affect and emotion shape cultural interpretations of and socio-political responses to HIV risk and responsibility. Our approach reflects a growing interest in grounding the study of bioethics in recognition of how social processes mediate individual action, [23,33] it also dovetails with how solidarity amongst different groups might affect the context of decision-making. For example, according to Prainsack and Buyx:

In its most bare-bone form, solidarity signifies shared

practices reflecting a collective commitment to carry 'costs' (financial, social, emotional, or otherwise) to assist others. It is important to note that solidarity is understood here as a practice and not merely as an inner sentiment or an abstract value. Solidarity requires actions. Motivations and feelings such as empathy etc. are not sufficient to satisfy this understanding of solidarity, unless they manifest themselves in acts. [34 p46]

Given the historic solidarity between the ASO community and PLWHA we were interested in how the personal emotions of ASO staff members toward the criminalization of HIV/AIDS nondisclosure and the affective climate of frontline HIV/AIDS advocacy comes to shape the content and messaging of the counsel offered to PLWHA and of the ways in which staff conduct their day-to-day work.

Finally, Hedgecoe counsels that a critical bioethics must be "empirically rooted." [6] This article connects questions about risk and responsibility in the age of criminalization to the situated knowledge of the HIV/AIDS community, which includes individuals living with and at risk of HIV, as well as individuals working in the ASO sector. Our study findings demonstrate that the emotionally charged and ethically uncertain climate resulting from criminalization are being felt well beyond the direct daily encounters between individuals living with HIV and their actual or potential sexual partners. In the next section, we discuss the value of incorporating emotions into critical bioethics and use our empirical data to demonstrate how emotions are affecting frontline ASO work in Canada.

Results & Discussion: Incorporating Emotion into Critical Bioethics

The emotional turn has been felt throughout the social sciences, humanities, and law. [35-38] A central theme in some of the literature concerns the need to destabilize the separation of emotion from reason. If reason and emotions are inextricably linked such that rationality requires emotion, then it is unhelpful to pit feeling and emotion against cognition and reason. [39] Complex emotions such as compassion, disgust, fear and anger "express explicit principles that we hold, or mere intuitions that we have never fully articulated". [40 p17] Moreover, we attach certain moral ideas to our ability to express different emotions; for example, we might feel shameful about expressing anger, or indeed righteous.

Appreciating the role of emotions in bioethics led us to focus on advocates working in the ASO community to understand how they might challenge or reproduce dominant *feeling rules*, a concept first coined by Hochschild, and more recently explored by Gould, to reveal the ways in which rituals and

conventions capture, document, and codify felt experience. [37,41] Unlike other rules, feeling rules “do not apply to action but to what is often taken as a precursor to action”. [41 p564] Hochschild distinguishes a feeling rule – “our sense of what we can expect to feel in a given situation” – from rules that reflect “our sense of what we *should feel* in that situation”. [41 p564] Anderson invokes Raymond Williams’ concept “structures of feeling” to describe “forms of affective presence that disclose self, others and the world in particular ways. Structures of feeling mediate life by exerting ‘palpable pressures’ and setting ‘effective limits on experience and on action’.” [42 p106] When a PLWHA understands that HIV commonly evinces fear, disgust and stigma, these emotions become structures of feeling that can influence bioethical decision-making surrounding disclosure.

In adapting the notion of feeling rules to the bioethical field of HIV/AIDS and criminalization, we are interested in what is considered appropriate to feel in the ASO environment vis-à-vis criminalization, and whether this affects the kinds of discussions that take place regarding nondisclosure. Of course, HIV/AIDS advocacy has never been devoid of emotion; consider, for example, the long-standing tradition of activism popularized by the AIDS Coalition to Unleash Power that legitimized anger as a collectively felt emotion. [37] While staff might be encouraged to act professionally, which requires working ‘at a distance’ when dealing with clients who seek their counsel, such professionalism might be frowned upon in a community built on relationships of trust, love, and feeling. What are the implications of appearing to be unfeeling? In some cases, the inability of staff members to express empathy or compassion can contribute to feelings of shame among clients.

Members of the ASO community are not simply expected to provide reliable or “objective” information and counsel to PLWHA. Instead, they must grapple with the need to reconcile “on the ground” bioethical decision-making with the ever shifting and uncertain terrain created by criminalizing HIV nondisclosure. Subsequently, bioethical decision-making on the ground may depart from what would be considered legally responsible conduct. For example, like many of the participants we interviewed, Andrew reported that his understanding of what constitutes responsible sexual conduct is often challenged by the day-to-day realities of exercising professional ethics:

I’ve got guys who are concerned about going and getting tested for HIV because they’re afraid that the test results will be shared with their wives at home who have no idea they have this lifestyle [Men who have sex with men]. So for me, that’s a hard one

for me on my personal values test, in that cheating is cheating, and if you’re engaging in risky sexual behaviours behind your partner’s back without their knowledge and not getting tested to ensure that you’re not putting them at risk, I find that very difficult to wade through, and it’s a bit of a minefield, but you have to really tiptoe.

Andrew’s statement that ASO staff must “tiptoe” as they “wade through a minefield” reveals how many different circumstances and individual emotional responses (e.g. their own, the client’s, as well as those of the client’s partner, family and community) they must consider when counselling about disclosure. Moreover, they must do so without revealing any personal judgments they may hold regarding the individual’s behaviour in order to try to ensure that the service user maintains contact with the ASO. On the other hand, bioethical uncertainties that challenge personal ethics can lead to personal soul searching and frustration:

I’ll talk to one of my other peers about stuff and say, “I just need to talk to you. I need to vent this shit out of here. This guy’s just driving me crazy. His test has come back positive. He doesn’t want to tell his wife, but he’s not sleeping with his wife, so really, does he need to tell his wife?”

The collision of professional ethics, feelings of solidarity with PLWHA, and personal emotions and morals created other bioethical conundrums for ASO staff. Most notably, participants raised concerns about counselling service users to disclose when the client is known to be in a violent relationship or might be at risk of violence if they disclose. Counselling clients to engage in blanket, universal disclosure to all of their sexual partners reflects ASO workers’ fear of criminalization but it goes beyond the requirements of the legal obligation set by the ‘realistic possibility test’ and it may simultaneously increase the potential for risk and harm to clients. Indeed, while most ASO staff members are philosophically opposed to criminalization, traditional bioethical principles are often of little help when trying to respond to legitimate, on-the-ground issues faced by people living with HIV. Reflecting this common concern, one frontline worker stated:

I go back to the client being afraid to tell their parent or being afraid to tell their spouse or their pimp, and I know they’re going to end up having sex with them. And knowing that the condom might not work [Pauses] that’s my hardest part because there’s nothing I can say. I have to – I understand why. I’m sorry, but if I’m going to get the bejesus beaten out of me because I now have HIV, I’m not going to want to tell people. I get that.

The AIDS movement’s success in challenging medical and scientific authority was an important factor driving our

interest in exploring the ways in which new, bioethical considerations emerging from shifting medical and legal discourses are reshaping the contours of HIV/AIDS advocacy. These questions often surface with respect to the emotional labour advocates are required to perform in order to translate complex ethical-medico-legal knowledge into accessible language to their clients, all the while trying to maintain some, but not too much, professional distance. For example, while ASO staff may understand that the risk of transmission varies by sex and by sexual position and activity, the legal precedents set by the SCC rulings, which only considered heterosexual penetrative vaginal sex, complicate their efforts to provide clear advice and counselling regarding the duty to disclose. Mary Anne summed up the issue this way:

I honestly don't understand [the criminalization of HIV nondisclosure]. I think that's the biggest problem – is I don't understand, and when I don't understand, I get agitated, and I get angry. And I'm sorry. My clients – all of them – even the ones on the street that are working the street – are not bad people. That's just there but for the grace of God go you or I. (...) Not being a lawyer and not understanding the fine print of everything and coming from the just common sense model of everything, a lot of times, I end up being tongue-tied because I don't want to say the wrong thing to you.

Mary Anne's narrative illustrates what many participants noted – that the legal requirement to disclose one's HIV status to all sexual partners is not as straightforward as law's rational actor might suggest. While legal norms assume that the rational actor has access to all available information and takes the most beneficent and just course of action, self-determined reasoning (reflecting the bioethical principle of autonomy) is highly influenced by emotions, structural power relations and socio-cultural context. This means that in some situations, decisions to disregard the law do not reflect irrational or purposively reckless behaviour, but rather the messiness inherent in complex, emotional decision-making. Consequently, such decisions must be read with an eye to the affective economy that emotional and power relations engender, rather than what is assumed by the objective calculus of the rational actor identified in the fields of bioethics and law. For a woman in a violent relationship, the decision to forestall disclosure – while risking criminalization (a harmful cost) – may help to prevent victimization (a potentially life-saving benefit).

The law creates feelings of uncertainty, apprehension, anger and fear, not only for PLWHA but also for the broader ASO community that is charged with communicating accurate, reliable information and counsel. Reflecting upon how

stigma and discrimination make many PLWHA reluctant to universally disclose and the dangers this may pose in cases where soured relationships perpetuate vengeful calls for criminalization, as was the case in *R. v. D.C.*, one participant averred:

And I totally get why they're not – stigma, the discrimination, all the shit that comes with disclosing one's HIV status when – until this disease isn't criminalized, we're fucked around disclosure. People will not do it so long as they're afraid they're going to be charged somewhere down the road. He said, she said – we've seen too many cases in the courts of I disclosed. Five years later, we divorced. Now, the dick's charging me. What the fuck?

Given the climate of fear around disclosure that criminalization exacerbates, some PLWHA have gone to great lengths to ensure that their disclosure is documented and preserved. While Medina reported that some ASO staff counsel clients to store used condoms in the freezer as proof that they practiced safer sex should they be criminally charged,[31] a number of interview participants relayed that some of their clients are drawing up disclosure contracts for their sexual partners to sign. Exemplifying solidarity with other PLWHA, one participant noted that he has used this approach himself and that he recommends his clients use disclosure contracts as a method of legal protection:

As an educational measure to the guys I talk to who are disclosing their status, I encourage them to keep all conversations – so ideally, get a witness in the bar to the fact that you disclosed your HIV status to buddy who wants to take you home. Good luck with that. Have a document at home that says, and make them sign it. There was a time when I actually had one in my home – a document that I signed that I made people sign: I told you I was HIV-positive; this is what we're going to do, this is da, da, da, da. You agree, blah, blah, blah. End of discussion.

The bioethical challenges associated with the criminalization of HIV/AIDS nondisclosure are rooted in the context of medico-legal uncertainty that characterizes the environment within which members of the ASO community work and PLWHA live. We suggest that these bioethical challenges mobilize strongly felt emotional responses because they target highly stigmatized and vulnerable groups. Rooted in emotions of disgust and fear of the 'dangerous other',[2] criminalization fosters the problematic and inaccurate view that PLWHA who choose not to disclose are consciously trying to transmit HIV to others. As a result, criminalization maintains and even augments the stigma that has long been attached to HIV/AIDS and effectively dehumanizes PLWHA. Given that the legal system channels cultural emotions,[35,38] it is unsurprising that socio-legal scholars

have identified trends indicative of the re-emotionalization of law in two arenas: “the emotionalization of public discourse about crime and criminal justice, and the implementation of sanctions in the criminal justice system that are explicitly based on—or designed to arouse—emotions”.[43 p301]

Conclusion

This article highlights some of the bioethical challenges unfolding in the wake of a changing HIV epidemic. While the use of the criminal law to punish PLWHA has been roundly criticized as poor public policy, less attention has centered on how the intersection of public health and criminal law is reconstituting the HIV-positive subject as an always-already, potential sexual predator.

Advancing a critical bioethics approach to study the criminalization of HIV nondisclosure, we focused our attention on how counsel regarding the duty to disclose is being considered in the ASO context. While the field of bioethics forces us to confront uncertainty, not knowing how our individual decisions will directly affect others, and over what course, means that we are rarely “rationally” accessing comprehensive information about the risks and benefits associated with our actions. Subsequently, there is much to be gleaned from investigating the environments in which these difficult decisions are made. While Battin et al. are correct to suggest that we possess “embedded agency”, we need to unpack the environment in which the individual is embedded to examine how it contributes to defining what it means to behave responsibly or ethically in the age of epidemic.[29 p89]

Having established that both medical and legal knowledge related to HIV are ever-evolving and are contributing to an environment of bioethical uncertainty, we view the ASO community as a collective of key actors who translate these uncertain knowledges to PLWHA and perform their own emotional labour in the process. By examining how ASOs communicate shifting medical and legal knowledge to PLWHAs, we hope to shed light on how bioethical decision-making might be structured not only by a range of interlocking oppressions related to gender, race/ethnicity, class and sexuality, but also by affect and emotion. Adding emotions and affects to our analytic lens enabled us to challenge the problematic conceptualization of the rational actor that is located in bioethics and law,[5,6,29] especially in light of the (re)emotionalization of law.[36,38,43] We argue that the vexing moral and legal questions that are emerging as a result of the criminalization of HIV/AIDS nondisclosure and that are faced by PLWHA and ASO workers alike are

mediated by a range of conscious and unconscious emotions and affects. This finding suggests that scholars working in the field of bioethics must move beyond the traditional principles of autonomy, nonmaleficence, beneficence and justice and begin to consider the ways in which emotions shape bioethical decision-making ‘on the ground’ and therefore in varying intersectional and socio-cultural contexts. Finally, establishing the importance of everyday bioethical decision-making – Heimer’s bioethics on the ground – in the advocacy field can contribute to valorizing the emotionally challenging work performed by these advocates.[8]

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