

**Abstract**

The growing professionalization of AIDS Service Organizations and the criminalization of HIV nondisclosure have reshaped staff charting practices. Building on a recent national research project in Canada, we conducted semi-structured interviews in February-April 2017 with N=12 staff in Atlanta, Georgia to investigate charting practices in the context of HIV criminalization. Our data showed no variation between professionalized and peer staff in terms of charting practices, although the American participants reported being less protective about the content of their notes and less concerned about the risk their notes may pose to criminal prosecution of alleged HIV nondisclosure than was previously reported by their Canadian counterparts. We identified a false sense of security among American staff stemming from their belief that the Health Insurance Portability and Accountability Act (HIPAA) would protect against disclosure of charting notes. We suggest training and educational opportunities are needed to sensitize staff to the implications of record-keeping on the prosecution of HIV nondisclosure.

**Key Words** ASO professionalization, charting practices, criminalization of HIV nondisclosure, HIPAA

**“We document everything”:  
Interpretations of HIPAA and their impact  
on ASO staff charting practices in the  
context of HIV criminalization in the state  
of Georgia**

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**Introduction**

Failing to disclose HIV seropositivity prior to sex is criminalized in both Canada and the United States.[1,2] Unlike Canada, where the creation and ratification of criminal law is the sole jurisdiction of the federal government, laws governing the criminalization of HIV nondisclosure in the United States vary by state.[1,3] As of 2019, 34 states criminalize HIV exposure in some form.[4] Most states criminalize HIV nondisclosure to sexual partners, while other states also criminalize behaviours

that have no risk of HIV transmission, such as spitting.[5] Georgia, where this research was conducted, criminalizes knowingly exposing HIV without prior disclosure via sex, biting, spitting, needle sharing, and blood or body tissue donation; it is also important to note that HIV transmission is not required in order to press criminal charges.[6] Between 2008-2019, there have been at least 24 cases of HIV criminalization in Georgia (out of 411 countrywide), although this is an illustrative, not exhaustive list.[7] Especially problematic is that at least six of these 24 cases involved conduct that presents low to no risk of HIV transmission, such as biting or spitting,[8] and the fact that transmission was only confirmed in three of these 24 cases, while no transmission was confirmed in four cases.[6,7] Notably, HIV transmission is similarly not required to lay criminal charges in Canada, although charges may only be brought against those who fail to disclose prior to sex.[9]

Scientific evidence now demonstrates that people living with HIV (PLWHA) who adhere to antiretroviral therapy and achieve a low viral load (less than 1500 copies of the HIV virus per ml

of blood) pose a “negligible” risk of transmitting the virus to their sexual partners, even without using a condom. Even more telling is that individuals with a suppressed and undetectable viral load (<200 copies/ml) are unable to transmit the virus. In common parlance, medical experts now use the term U=U, or undetectable=untransmissible, to describe this phenomenon.[10] In *R. v. Mabior*,[11] the most recent precedent setting Canadian case involving HIV nondisclosure, the Supreme Court of Canada held that disclosure of one’s seropositivity prior to sex is not required if the person’s viral load is low (<1500 copies/ml) or undetectable (<200 copies/ml) and the person uses a condom, which, in the Court’s view, precludes a realistic possibility of transmission.[9] Recent legal developments, by way of federal prosecutorial guidelines that apply to the territories and similar directives that have been adopted by some provinces (Alberta, British Columbia, and Ontario), have made it less likely for someone with a suppressed viral load to be prosecuted for nondisclosure if a condom is not used.[12] However, there is less certainty for those with an unsuppressed viral load (>200 copies/ml) who use a condom but do not disclose.[12] Only in the territories and the province of British Columbia is there a policy basis that someone who does not disclose and engages in oral sex (which has a very low, if any, risk of transmission) should not be prosecuted.[12] While these Canadian legal developments reflect some early recognition of the advancements made in current HIV science, there is a strong call for the federal government to codify these developments in the *Criminal Code*, as opposed to the current piecemeal approach that relies on prosecutorial directives that vary across the country.[12] US state laws have yet to recognize important medical advancements, which further illustrates how HIV criminalization is not based on scientific evidence of the actual risks of transmission, but is instead rooted in and fuels stigma and discrimination against PLWHA.[9,13]

Central to HIV criminalization efforts in both countries is the use of the legal subpoena to summon different witnesses to either testify in court or to provide written documents as evidence. This often includes subpoenaing medical doctors and staff working in the AIDS Service Organization (ASO) sector to testify and/or supply their case notes and charts in order to determine when the accused first came to learn that they were HIV positive and whether or not they reported that they had failed to disclose their seropositivity to a sexual partner. ASO staff generally provide education and support services for PLWHA, which means that testifying or supplying case notes threatens the rapport and trust between ASO workers and PLWHA who seek out and utilize their services.[9,14] Given this development, it is important

to remember that combatting the stigmatization and criminalization of PLWHA was central to AIDS activism in the 1980s and that AIDS Service Organizations (ASOs) emerged as part of this grassroots movement.[15] Over time, however, ASOs began to experience an increasing professionalization of their services and bureaucratization of their organizations, which critical scholars like Kinsman marked as a shift away from the volunteer and peer-based nature of early AIDS activism that created barriers for PLWHA to be involved in ASO management.[15,16] Professionalization, compared to peer relationships, introduces more defined service delivery standards and stronger boundaries between service users, now reimagined as clients, and service providers.[17]

In the US context, where this research was conducted, threats to the trust relationship between ASO staff and service users also stem from the limitations set to the “privacy rule” for the federal government’s *Health Insurance Portability and Accountability Act*. Commonly known as HIPAA, this piece of legislation required the creation of national standards to protect sensitive patient health information from being disclosed without the patient’s consent or knowledge. However, HIPAA’s privacy rule permits the use and disclosure of protected health information, without an individual’s authorization or permission, for twelve national priority purposes – four of which are relevant herein. What are known as “covered entities” (i.e., healthcare providers, health plans, healthcare clearinghouses, and business associates) may disclose a patient’s health information without their knowledge or consent when: (1) it is required by law; (2) in a judicial or administrative proceeding if the request for the information is through an order from a court or administrative tribunal, or in response to a subpoena or other lawful process; (3) when there is a serious and imminent threat to the health or safety of an individual or the general public and the disclosure is made to someone thought to be able to prevent or lessen the threat (including the target of the threat); and (4) for law enforcement purposes under the following six circumstances:

- (a) as required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests; (b) to identify or locate a suspect, fugitive, material witness, or missing person; (c) in response to a law enforcement official’s request for information about a victim or suspected victim of a crime; (d) to alert law enforcement of a person’s death, if the covered entity suspects that criminal activity caused the death; (e) when a covered entity believes that protected health information is evidence of a crime that occurred on its premises; and (f) by a covered health care provider in a medical emergency not occurring on its premises, when necessary to inform

law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.[18]

A recent proposal has sought to expand HIPAA's privacy rule to permit disclosure to avert a threat to the health or safety at the lower legal standard of a serious and reasonably foreseeable threat, instead of the current more restrictive standard of a serious and imminent threat.[19] Critics of this proposal charge that the lower standard could increase the flow of private health information to law enforcement and potentially widen harmful penal consequences for PLWHA, especially for conduct that has little, if any, risk of transmission, such as biting or spitting.[20]

Building on earlier research in Canada that found formally regulated professionals feel more compelled to document discussions about nondisclosure than do peer ASO staff,[9,14] our project examines: (1) whether this is replicable within our sample of Atlanta-based ASOs; and, (2) how understandings of health privacy legislation underpin ASO staff charting practices.

## Methods

### Ethics & Recruitment

This research builds on a national project conducted by the first author in Canada between 2014-2018 by adding a small American sample. Having received ethics approval from the University of Ottawa's Research Ethics Board in January 2014 for the original project, the first author modified that ethics proposal to secure ethics clearance to conduct interviews in Georgia, where she was taking up a Fulbright Research Chair position. After relocating to the US in January 2017, the first author contacted the Executive Directors (EDs) of ASOs across the Atlanta region and used snowball sampling to identify local community health centres from which to recruit participants. The EDs forwarded an information sheet to staff, who emailed the first author to indicate their interest in participating. Recruitment took place throughout the four-month duration of the first author's tenure in the US and all ASO staff members who expressed interest in participating were interviewed; ultimately, twelve in-person, semi-structured interviews were conducted between February-April 2017.

Throughout the interviews, participants discussed: their knowledge about the law and available resources; personal and client concerns about criminalization; emotional responses to client accounts of disclosing/not-disclosing; and how criminalization affects charting practices and counselling. Interviews were digitally recorded and transcribed verbatim.

## Thematic Analysis

The data were analyzed using a constant comparative approach to thematic analysis.[21] First, we read and discussed the transcripts to understand the data. Second, we generated codes (independently, then together) to describe the participants' statements. Using an Excel file allowed us to track saturation of codes (horizontal axis) across participants (vertical axis). Third, we combined the codes to identify the themes discussed herein. Fourth, we reviewed the transcripts again to ensure the themes accurately reflected participants' responses and searched for discrepant cases, finding none. Fifth, we established the nature and scope of each theme and selected quotes that reflected the points made in relation to each theme. Despite the small sample size and exploratory nature of this qualitative research project, saturation, which is commonly described as a kind of information or data redundancy, where no new information, codes or themes are evident in the dataset usually signalling that the researcher can end the data collection phase, was reached across the three themes presented herein.[22] Notably, the tracking of code saturation was conducted after recruitment had stopped again due to the limited time the first author was able to spend in the US. While recruitment often continues until data saturation is reached, thematic analysis can be done without saturation, especially with a small number of participants.[21] We follow qualitative scholars like Hammersly,[22] Low,[23] and Braun and Clarke[24] who reject attempts to operationalise the concept of saturation via quantitative measures or that embed the concept with a fixed meaning, which not only contrast qualitative research paradigms that recognize that there is always potential to develop new understandings of a dataset due to the subjective role the researcher plays in interpreting meaning, but also for relying on assumptions about qualitative research, thematic analysis and themes that are antithetical to approaches that prioritise qualitative research values. We do recognize and acknowledge that while the themes we identify were noted across participants in this study, we cannot generalize these findings to all American ASO staff members.

## Limitations and Suggestions for Future Research

Given the limited time the first author was able to spend in the US, she concentrated on recruiting ASO staff for interviews in order to mirror the national project she conducted in Canada on the role that ASO staff play as interlocutors who educate PLWHA about the public health and legal risks they must navigate and manage in relation to their seropositive HIV status. Other research limitations for this project include the

small-scale exploratory design and the fact that American laws on HIV criminalization vary across each US state, both of which preclude generalization to the wider US context.

Future research should include interviews with PLWHA and ASO staff (both peer and professional) who have directly experienced the subpoena process in relation to HIV criminalization, as these first order experiences will provide greater insight into how these groups understand the legal privacy protections between ASO staff and clients and the impacts criminalization has on their respective disclosure, testing, and educational practices. Future research should also take care to evaluate how the new medical evidence of U=U is being taken up by the courts (in both Canadian and American legal contexts) as well as in ASO staff discussions of nondisclosure. Future research should also examine how HIPAA affects prosecutions under HIV criminalization laws.

## Results

This research reflects the findings gleaned from 12 interviews with staff across four ASOs in the Atlanta region of the state of Georgia, USA (six women – three Black, two white, one white/Native; six men – two Black, three white, one Latino). Nine were considered professional staff and three were considered peer staff based on the position they held and the formal education required for the position. While all of the peer staff engaged in counselling support work, professional staff occupied positions including, program manager, medical case manager, intake and eligibility specialist, executive director, housing specialist, HIV prevention and education specialist, medical and infectious diseases director, and client services coordinator (who was also a certified HIV specialist with the American Academy of HIV Medicine). Some of these staff members were registered social workers and nurses and therefore members of professional oversight bodies. To contextualize what these different roles mean within the context of disclosure counselling and charting practices, it is important to note that it would be the medical case managers, medical and infectious diseases director, intake workers, and, perhaps surprisingly, the housing specialist who engage in more direct charting of their conversations with individual clients. Given the added complications for HIV management that are wrought by poverty, the housing specialist reported that they often have discussions that touch on a variety of issues beyond housing assistance. Notably, all of these staff members have the ability to make notes in a client's file and it is the general file that could be subpoenaed should a client be charged with nondisclosure, although it is the medical case managers and social workers who are most likely to be subpoenaed to testify as to the content of these files in court as they function as primary case workers.

Three primary themes were uncovered: (1) participants

expressed little concern that their case management notes would be subpoenaed or used in criminal proceedings; (2) participants felt that the *Health Insurance Portability and Accountability Act* (HIPAA) would protect them from turning over their charting notes; and, (3) staff members lacked training specific to HIV criminalization.

## Charting Practices

Most participants reported taking detailed notes about the content of their disclosure discussions and general interactions with clients. Some claimed that they do this as a form of personal protection and to protect the trust relationship with their clients. As the following quote demonstrates, staff aimed to prevent misunderstandings by avoiding possible accusations of having said something they did not say:

We document everything. Well, I should say, we're supposed to document everything. I document everything... Because it never fails that the one time you don't, it's the one time somebody comes back and says you said something that you probably didn't say... If someone does talk about criminalization we're supposed to document what we talked with that person about... For instance, someone said 'I had this one-night stand and we had unprotected sex and I didn't tell them I had HIV'...that would go in the chart. (Woman, Housing Specialist)

Interestingly, the few participants who reported that they did not take detailed notes about their discussions about (non) disclosure, did so either because of a perceived lack of their utility or because explaining the legal requirements for disclosure is not a component of the intake process, rather than as a protective behaviour against potential subpoena and use in criminal proceedings. As one participant commented, it is not useful to take detailed case notes for every service user because "I'm not going to see these people again" (Man, AIDS Information Line Coordinator). Another participant reported that criminalization "is a fleeting conversation" and disclosure "is not a standard part of the interview intake process... it's nothing formally documented... We're not really instructed on that" (Woman, Intake and Eligibility Specialist).

In fact, only one participant reported engaging in protective behaviours against potential subpoena. This professional staff member reported that they do not try to produce a transcript of their meetings and conversations with service users, which would be inaccurate without recording them, and instead focus on documenting the general content of their discussions in the case file:

I don't like to do too many quotations or what was specifically said because I don't have a transcript in front of me. And sometimes that one word can make such a difference that if that wasn't the word that was used, I don't want to document that that word was used... There are certain things that I've documented

in a way, like if this gets subpoenaed, I want to make sure that this is documented. But on a general day-to-day, it's kind of more impressions, patterns, what was talked about, what are the plans for the future, but not necessarily the exact wording of everything. (Woman, Medical Case Manager).

This position illustrates that some ASO staff do take extra caution in terms of what they include in a client's chart, knowing that there is a risk that their notes may be subpoenaed. Overall, however, participants for the current study did not seem as protective about the use of their notes in criminal prosecutions of alleged cases of HIV nondisclosure as their Canadian counterparts, who claimed to "write as little as we have to" and to adhere to the motto that writing "less is more" as the best way to protect clients by minimizing the usefulness their charting records might have for the courts.[9] As the above quotes show, US participants were more likely to report that they "document everything". With respect to this point, it is important to remember that the small sample size of the present study is a limitation in terms of making any broad generalizations and that a larger US based study would be required in order to glean a clearer picture of this trend across the state of Georgia and the wider country. Also in contrast to earlier findings in Canada, our data showed no variation between professionalized and peer ASO staff in Georgia in terms of charting practices.[9,14] With only one professional participant reporting that criminalization changed how they do their work by encouraging them to be more cautious in terms of what they document, it does not appear that the professional obligations of regulatory bodies, such as the Georgia Board of Nursing or the Georgia Composite Board of Professional Counselors, Social Workers and Marriage and Family Therapists, affected the charting practices of professionalized ASO staff differently than non-regulated peer ASO staff. This finding can be explained by how participants interpreted the protections provided by HIPAA legislation.

### HIPAA and a False Sense of Security

Signed into law in 1996, the United States *Health Insurance Portability and Accountability Act* (HIPAA) guides the flow of healthcare information, stipulates how personally identifiable information maintained by the healthcare and insurance industries should be protected, and addresses limitations on healthcare insurance coverage. Participants reported strong trust and confidence in the legal protections afforded to the client-service provider relationship against the disclosure of records noted in HIPAA, even in cases involving potential criminal prosecution:

Well, here, at least agencies, health care providers

are bound by HIPAA... and they can't disclose health information without a written waiver. (Man, AIDS Information Line Coordinator)

[Even if disclosure of an intent to infect others] is in the person's medical history, as well as instances where they've disclosed substance abuse or other things that may be criminally liable [we] are protected by this client-provider relationship. (Man, Client Services Coordinator and Certified HIV Specialist)

These two quotes reveal a slight difference in how the two participants understand HIPAA's privacy protections. While the first participant notes that with a "written waiver" their notes may be released; the second participant mistakenly believes that their notes are fully protected – even from law enforcement. From this perspective, it makes sense that the participant would aim to document details about any disclosure discussions they have with their clients as it would make their efforts to recall a client's history easier, which would facilitate communication and trust in the counselling relationship and thus has the potential to make them more efficient in their work.

Similarly, participants reported little concern about the dangers or likelihood of a client's file being released through subpoena or court order, variously noting that a judge would have to approve the release of a client's medical record, that lawyers have "a lot of hoops" to jump through to secure private information, and that it is just the medical information (e.g., date of HIV positive test results reporting) that would be requested:

Nine times out of ten, they probably won't release the personal information, because HIPAA laws protect that, unless it's an HIV criminalization case. The courts can subpoena partial records, but they can't get the whole record. What they can ask for, "has this person come in and get tested, and when [did] they come in and get tested? What were the results of that test?" That's it. Unless it's a federal judge that says, "hey, we need this particular file", most [of the] time, they won't get that file. (Man, Linkage to Care Specialist)

And I think HIPAA does protect a certain amount of that. They would probably have to jump through a lot of hoops like going to a lot of different lawyers and things to get that information. (Women, Housing Specialist)

I don't necessarily worry about [disclosure of records] because it's more medical records would have to be subpoenaed, HIV test results would have to be subpoenaed, and most of the time that's more to people's advantage and not to their disadvantage. (Women, Program Manager)

Suggesting that sharing medical records would be to the

advantage of PLWHA only speaks to those cases where this would corroborate a client's claims that they adhered to their medications regimen and maintained a low or undetectable viral load. This view fails to consider other charting details that may disadvantage the individual should they be criminally charged (e.g., evidence that they failed or hesitated to disclose). While these perspectives reflect some misunderstanding of the limitations to privacy afforded by HIPAA and a certain degree of naivete about what information can be subpoenaed, from the vantage point of the participants who thought HIPAA would prevent the release of their notes it makes sense that they would feel comfortable documenting details about their disclosure discussions, which, as aforementioned, may facilitate their ability to do their work more efficiently and to build trusting relationships with their clients.

Given that it is standard legal practice to subpoena the accused's medical records in HIV nondisclosure cases to establish evidence that the accused knew of their HIV infection and the legal duty to disclose, it is surprising that only one participant reported that disclosing records through subpoena could harm the patient-provider relationship:

Absolutely, the judge or the court system can subpoena medical records and see when the person was diagnosed and what date they were diagnosed, what conversations took place, did they disclose to their medical provider or their mental health provider that they were not disclosing their status to individuals and that can be used against them. (Man, Client Services Coordinator and Certified HIV Specialist)

Unfortunately, tracking arrests, prosecutions, convictions, or how often client records are subpoenaed (in Georgia or nationally) under HIV criminalization laws is a challenge because there is no central repository or system for reporting those data.[6,7] Therefore, while our findings suggest that participants have a false sense of security regarding HIPAA's protective effect against the release of their charting records, the lack of this information makes it difficult to gauge the accuracy of participants' confidence about the safety of their charting records. Moreover, while participants were aware that police may subpoena their notes for use in legal proceedings against their clients, none experienced this nor did they report having colleagues who did, which means that their faith in HIPAA's protective powers have never been tested. This suggests that participants grounded their interpretation of HIPAA as affording them a kind of protective shield in their work experiences rather than in a close reading of the legislation itself. This leads to our final point regarding the need for increased training and education about HIV criminalization.

## Training and Education

Participants reported that they received little training or education on issues related to HIV criminalization, including the disclosure of client records through subpoena for use in criminal prosecutions alleging nondisclosure:

I don't believe we had a formal training. Uh, to be perfectly candid, the training is not very structured. (Woman, Medical Case Manager)

We're not really instructed on [documenting discussions about criminalization]. I think our prevention people may have a little bit more, but on the case management side, it really is one of those, if it's asked about, then it's "oh, let's find a resource", but beyond that, no. (Woman, Intake and Eligibility Specialist)

In fact, only two professional staff participants reported having received some training on issues of criminalization. Unsurprisingly, participants reported median confidence about their knowledge of HIV criminalization, noting that it is generally not included in HIV care provider education, even for professionalized staff:

If I had to do [a] knowledge rating [of criminalization issues] on a scale, it would be very, maybe in the middle, like a five out of ten. (Woman, Infectious Diseases Director)

[Criminalization] is not something that we really talk a lot about. There's not a lot of HIV specific education in medical schools, in general, because it's something that's lumped in with infectious diseases but it's not something that you spend a lot of time on. (Man, Client Services Coordinator and Certified HIV Specialist)

Our data show that neither professionalized nor peer ASO staff receive direct training on HIV criminalization. Participants reported that their knowledge of this issue came from on-the-job learning: "It's kind of a fly by the seat of your pants, learn as you do, and you kind of pick things up as you go." (Woman, Medical Case Manager).

Despite recognizing their lack of knowledge on this topic, some participants reported they did not perceive a need for such formalized training:

We can request training in any one area that we want to, and we have a supervisor for that. But with criminalization, they, I've never felt the need to receive training. (Man, Medical Case Manager)

And because the laws are changing... and it doesn't always directly affect what you're doing day-to-day, it's up to you to decide whether or not you're going to take advantage of those opportunities. So, it's not something that's made mandatory. (Woman, Housing Specialist)

While these ASO worker participants seemed to consider discussions about HIV criminalization to be outside of their role and the scope of their professional work, some to the point that they do not opt for or see the need for formal training or education on this subject, it would be a mistake to assume that this finding has no impact upon or implications for ASO staff charting or counselling practices. The fact that participants did not perceive a need for this training raises concerns that they may not sufficiently understand the severity of HIV criminalization, including the impact clinical notes and other documentation may have on the prosecution of PLWHA. While this relates to our earlier finding that participants believe that the HIPAA legislation protects them from having to release client records, we also suggest that the fact that none of the participants had experienced the subpoena process personally or knew a colleague who had, illustrates how the lack of a first-order experience is problematically leading ASO staff to the fallacious conclusion that HIV criminalization is not a major issue in or impediment to their work.

## Discussion

Schouten and Brendel contend that the common misperceptions that HIPAA affords legal privilege to client-service provider relationships and protects against the exchange of personal medical information can lead clinicians to perceive it as a source of potential liability, even experiencing what they characterize as “HIPAAranoia,” a paranoia of HIPAA.[25] In these cases, the authors found clinicians to take up a more “defensive practice style grounded in legal and risk management hypervigilance” that led to less detailed charting documentation.[25] This is consistent with Touchet et al.’s argument that misinformation about HIPAA creates fear of potential penalties for non-compliance.[26] Ironically, “HIPAA actually facilitates the exchange of information... by allowing the exchange and release of information... without specific informed consent.”[25]

We too found evidence of misperceptions about HIPAA; however, our findings diverge in that our participants held misperceptions that contributed to an overly positive rather than a negative view of HIPAA. Participants reported great confidence in the legal protections afforded by HIPAA to the client-service provider relationship, making Sobel’s point that HIPAA facilitates the disclosure of health information “by permitting broad and easy dissemination” all the more troubling in the context of HIV criminalization.[27]

Our concern is that misinterpretations of the protections afforded by HIPAA among ASO staff may inadvertently contribute to the criminalization of PLWHA. Participants appeared to view HIPAA as more protective of health

information than it might actually be, given that police have the power to subpoena ASO case records. On one occasion, a participant (Male, AIDS Information Line Coordinator) referred to the full title of HIPAA as the “Health Information Privacy [sic] and Accountability Act”, when it stands for the *Health Insurance Portability and Accountability Act*. This confirmed our concern that some ASO staff believe that the sole or main purpose of HIPAA is to protect the privacy and confidentiality of health information.

While HIPAA does protect privacy, it also permits the disclosure of health information to law enforcement in specific circumstances, such as through subpoena, without the individual’s written authorization.[28] Erroneously, participants had strong confidence that HIPAA protects against disclosing records for use in prosecuting an HIV nondisclosure case likely because they had no direct experience with having their notes subpoenaed. Our findings contrast earlier research in two ways.[9,14] First, ASO staff in Atlanta do not readily associate their charting practices with the potential for those records to be used in criminal prosecutions of HIV nondisclosure. Second, we found no difference between the charting practices of professionalized and peer ASO staff in Atlanta; although, with the small sample size overall, especially of peer ASO staff participants, this finding should be studied further in a larger project.

As both professional and peer ASO staff reported that they “document everything”, we suggest that this second point may be one of the outcomes of the increasing professionalization the ASO sector has witnessed over the past three decades.[15] The push or pull to document disclosure discussions and details of clients’ disclosure practices may, however, create ethical tensions for ASO workers who must now attempt to balance the safety and well-being of their clients against the mandates of their professional positions as well as against the potential legal implications they might face if they either fail to document or act on reports of nondisclosure.[29] While participants did not speak to this notion of ethical tensions in their work, nor did we ask direct questions about this during the interviews, we suggest that these tensions exist and that future research should endeavour to study this question in greater detail to see how they manifest for and are addressed by different ASO staff members.

Our findings, albeit reflective of a small-scale study in one southern American state, differ from those generated in the Canadian context that show nurses[14] and ASO staff[9] feel similarly underprepared for criminalization discussions, but instead sought out additional training and felt they had adequate support from provincial and national HIV organizations who regularly offer educational opportunities

and provide written materials on this subject matter. Canadian ASO staff also reported that additional training on HIV criminalization led them to modify their charting practices in ways that would try to protect PLWHA or that would at the very least not facilitate their criminalization.[9] The danger here is that without adequate education on the subject matter, American ASO workers will continue to document in their case notes and charts the content of the discussions they have with their service users about their disclosure practices, which may include damning information revealed in private by the service user – for example, that they failed to use a condom or did not disclose their HIV seropositivity prior to sex – and that they may become embroiled in a criminal case against their client. Given that previous research in Canada found that upon receiving education and training about HIV criminalization ASO workers took extra precautions about the kinds of details they would document in their case notes,[9] our findings suggest that the lack of education and training is leading American ASO workers to miss the connection between what they see as the conditions and responsibilities of their work role and the way that their work can be taken up in a legal context in ways that can detrimentally impact PLWHA – an obvious ethical tension.

We suggest that training and educational opportunities for both professionalized and peer ASO staff are needed to sensitize them to the implications of record-keeping on the prosecution of HIV nondisclosure. Of course, such training may be more easily facilitated in the Canadian context given the smaller population, the fact that law is federally mandated, and that national HIV organizations such as the HIV/AIDS Legal Network do this kind of educational outreach.[9] Recognizing Schouten and Brendel's point that "clinicians should think clinically and leave lawyering to attorneys," we suggest that American ASO staff need more universal training and education regarding how the law may further marginalize and stigmatize their service-users by way of criminalization.[25] That said, it is important to note that participants spoke of being deeply committed to providing quality care to PLWHA and to the eradication of HIV stigma; strengthening their medico-legal awareness around criminalization will enable them to do this and to better serve their clients.

## Conclusions

Our US participants differed from their Canadian contemporaries in that they supported keeping detailed case management notes, largely because they felt a false sense of security from HIPAA. We must, however, consider that this finding may be tempered by the increased professionalization of the ASO sector or community that we have witnessed since the early days of the epidemic.[15,16] With more professional than peer ASO staff now working in these environments,

it is logical that more ASO staff members are adhering to regulated standards for charting practices that encourage detailed note-taking and which might reinforce certain taken-for-granted assumptions about the privacy protections that HIPAA avails to them – or, at the very least, that may lead professional staff to raise fewer red flags about the dangers of detailed note-taking in the context of HIV criminalization. The shift away from the volunteer and peer-based nature of early ASO work created barriers for PLWHA to become involved in ASO management.[16] Without the voices of PLWHA leading the HIV/AIDS service environment, there may be a decreased overall sense of understanding of how the bureaucracy of 'doing the job' might negatively impact PLWHA. Increased mandatory training and more readily available educational opportunities related to HIV criminalization would help to combat these misapprehensions and protect PLWHA from the stigma and harm that accompanies criminal prosecution.

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