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Foreword

One of the most pressing and difficult issues facing health care professionals at this time is the intersection of health and the law thus making this subject an important field of study—one which requires progressively increased attention. Indeed, the interface of criminal law and health care has transcended its traditional boundaries of reconstructing murder scenes and employing psychiatric practices, and now encompasses public health practices and HIV/AIDS care. Consequently, while psychiatry has a long-established tradition of discussing the legal and ethical implications of providing forensic care, it is now time for all health professionals, including nurses, to begin addressing the serious implications and complications that can arise when, not only health-related indicators, but also criminal law, dictates the outcomes, practices, and processes of front-line public health nursing practice.

In this special edition of *APORIA: The Nursing Journal*, Dr. Patrick O'Byrne and Dr. Marilou Gagnon, two professors from the University of Ottawa's School of Nursing, outline, present, and discuss a recent project, which sought to better understand the ramifications of the current context of criminal prosecutions for nondisclosure of HIV status on nursing practice, whether in the treatment, prevention, or public health domains. As part of this work, which was fully funded by a Canadian Institutes of Health Research (CIHR) meeting grant, these two professors (who are also registered nurses themselves) helped to shed more light on the contemporary health care context surrounding HIV care and the legally sensitive topic of serostatus disclosure/nondisclosure. As is evident, even after a cursory review of this document, these preliminary findings are a useful starting point for anyone wishing to better understand and/or further advance his/her general knowledge of this topic. Indubitably, one may discover useful material presented herein.

What is also important about this special edition of *APORIA: The Nursing Journal* is that it provides a practical example of how university professors can and, I believe, should interact with local health professionals in the interests of patients and populations. Instead of remaining comfortably ensconced within their offices, and safely publishing their results in research journals, these two professors returned to the root discipline of nursing (i.e., practice), and invited an array of front-line nurses to gather, free of charge, in a university setting. In this setting, these nurses were given the opportunity not only to learn from lawyers, College of

Nurses of Ontario (CNO) representatives, and legal policy analysts, but also to share, in turn, the wealth of knowledge that each of these nurses has acquired in their independent clinical practice settings. Rather than exclusively interacting with fellow academics and researchers, these two professors strove to reach the people who, ultimately, apply research findings in real-life settings. Dr. O’Byrne and Dr. Gagnon, moreover, executed this process in an interactive and communally beneficial way.

In closing, I invite everyone—not just HIV care providers, or students of forensic health care—to read this special edition of *Aporia: The Nursing Journal*. As criminal law begins to further influence the clinical practice of HIV care practitioners, perhaps it is time for more academics and researchers to begin working with front-line clinicians to ensure that patients, practitioners, and the general public are both aware of, and protected from, a criminal law system that is often informed by anachronistic governmental ideologies. It is time for all of us to examine how criminal law affects health care practices and, in many instances, undermines the quality of life that each of us experiences.

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Part 1: Introduction

At present, lawyers from the Canadian HIV/AIDS Legal Network are reporting that crown attorneys from across Canada have been prosecuting people living with HIV for failing to disclose their HIV-positive serological status (henceforth referred to as “serostatus”) with greater frequency.[1-3] Between 1998 and 2011, for instance, there have been just over 130 prosecutions related to serostatus nondisclosure in Canada, of which 59 occurred between 2006 and 2010.[2-5] Furthermore, more than 44 of these criminal proceedings were in Ontario.[2-5] This scenario makes Canada the jurisdiction with the second highest number of nondisclosure prosecutions in the world;[4,5] only the United States has conducted a larger number. In addition, the severity of the charges related to serostatus nondisclosure in Canada has increased from aggravated assault to aggravated sexual assault to first degree murder.[3-5] Lastly, according to the Canadian HIV/AIDS

Legal Network, 83% of the individuals who were convicted of serostatus nondisclosure were imprisoned.[4,5]

Simultaneously, the civil courts have also become involved in this matter: People, both HIV-negative and positive, have begun filing civil suits against health care institutions, health care providers, police departments, and governmental agencies, contending that these professionals, authorities, and institutions failed to warn them that they were being exposed to HIV.[4] In these cases, the plaintiffs—some of whom have since tested positive for HIV—allege that, because HIV is reportable in all Canadian jurisdictions and during immigration into Canada, these agencies and professionals knew that a person living with HIV was engaging in a form of unprotected sexual contact that could transmit HIV, and that she/he was potentially exposing others to the virus.[4] The plaintiffs further insist that these agencies and professionals failed to take reasonable steps to prevent HIV exposure and transmission, and thus that they are liable to pay damages.[4]

As a result, the number of criminal and civil proceedings relating to serostatus disclosure and transmission has steadily increased over the past few years, suggesting that there is a need to explore the effect of this particular phenomenon on health care settings and the practice of health care providers who work in the field of HIV/AIDS care.[6] In other words, it is imperative that researchers, academics, lawyers, and policy-workers address the perspectives of health care providers (e.g., nurses, physicians, and social workers), who work in the field of HIV/AIDS to examine how these legal precedents affect their daily practice, the quality of health care services received by people living with HIV, and overall HIV prevention efforts.[6]

The extant literature on the impact of criminal prosecutions for serostatus nondisclosure (nondisclosure prosecutions hereafter) on health care practice is, however, sparse.[1,5,6] While some authors have begun to examine the current trend of increased criminal/civil legal proceedings relating to HIV, there has yet to be much research that addresses the impact of these laws on clinical, public health, and/or administrative health care practice.[1,6-8] In other words, the extant literature about HIV and criminal/civil law discusses the current situation from the legal, public policy, and human rights perspectives, but fails to acknowledge the consequential/crucial scenarios that are faced on a daily basis by many health care providers who are involved in HIV/AIDS care: that is, HIV prevention, testing, management, and treatment. At present, few empirical data exist to help nurses address this issue in their front-line practice.[6-8] Furthermore, none of the current information about HIV and the law accounts for the fact that health care providers are not only bound by criminal law, but also by civil law,[4,9] professional standards,[10-14] public health legislation,[15] workplace policy,[11,13] and employment contracts. The unique situation that many HIV/AIDS health care providers face in their field likely makes it difficult for them to incorporate and use the extant legal and sociological literature on serostatus disclosure and the law because it is not pertinent to their circumstances.

One strategy employed to address this paucity of information was to organize a meeting that focused on the interplay of nondisclosure prosecutions and nursing practice. The goal was to bring together a group of nurses to discuss the effects of the current legal context that surrounds HIV, and to determine the strategies that nurses have been employing to address the repercussions that this situation has on their daily health care practice.

Attendance at this gathering was by invitation only. Ten

institutions received letters and posters inviting their nursing staff to attend an event that was entitled "HIV Criminalization and Nursing Practice".[16] (See Figure 1 for a presentation of the poster that each institution received.) Furthermore, each institution was assigned an approximately equal number of spaces, and were encouraged to send non-nursing health care staff who work in HIV/AIDS care if they could not send the designated number of nurses. The focus of the meeting, nevertheless, was to better understand the effects that nondisclosure prosecutions are having on nursing practice. There were no fees associated with attending this event, and snacks, coffee, and lunch were provided to all participants. A Meeting, Planning, and Dissemination (MPD) grant from the Canadian Institutes of Health Research (CIHR) was obtained to cover these costs.[17]

Lastly, although the legal context that surrounds HIV is an issue that is affecting nursing practice across Canada, Ottawa was selected as the target location for three reasons. First, as of 2011, 45% of all HIV-related prosecutions in Canada have occurred in Ontario (with many in Ottawa).[1,2,3] Second, while health care (e.g., service delivery, provider regulation, public health) is a provincial duty, infectious disease control is executed at the regional level in Ontario. Third, recent criminal/civil HIV legal cases in Ottawa have forced Ottawa-based front-line, administrative and public health staff to address this situation with little preparation and/or support. Discussions with these health providers, moreover, suggested that current strategies in Ottawa are neither research-informed, nor consistent across the city. Accordingly, the proposed meeting was an inter-professional discussion about HIV criminal/civil law in a region where these legal cases have had a profound impact.

The Meeting: "HIV Criminalization & Nursing Practice"

This meeting lasted one day (08h30-16h30), was divided into three sections, and was attended by 47 participants. Of these 47 individuals, 31 (66.1%) were nurses, one (2.1%) was a physician who worked in a nurse-led clinic, two (4.2%) were social workers who worked in the same nurse-led clinic, two (4.2%) were lawyers, and 11 (23.4%) reported being "other", such as, support staff, or peer counsellors. At the end, the participants were asked to complete a two-question survey about their length of experience in health care and HIV/AIDS care. In reply to the first question, the participants reported an average of 15.7 years of front-line practice in their chosen domain, with the minimum being less than one year of practice and the maximum being 40 years of practice. With

respect to the second question, the participants reported an average of 8.0 years experience in HIV/AIDS-related work, with the minimum being less than one year of practice and the maximum 23.5 years. See Table 1 for a summary of these data.

In the first section of this event, there were four keynote presentations: (a) Cécile Kazatchkine, a senior policy analyst from the Canadian HIV/AIDS Legal Network outlined the criminal law as it relates to serostatus disclosure and nondisclosure; (b) Jane Speakman, a public health lawyer described the public health legislation in Ontario that guides the mandatory reporting, follow-up, and management that surrounds HIV; (c) Lori Stoltz, a civil lawyer discussed the potential sources of litigation that were present in the health care practices that surround serostatus disclosure; and (d) Myra Kreick, a representative from the College of Nurses of Ontario (CNO) overviewed the relationship between professional nursing standards and serostatus disclosure.

The second part of this event involved small group discussions among the health care providers; these groups comprised eight groups of six individuals each. The discussions focused on exploring the participants' perceptions of how the current legal context has affected their daily work in HIV/AIDS care. Each group was facilitated by a nursing student from the University of Ottawa. Of the eight students, one was a doctoral candidate, five were at the master's level, and two were undergraduate students.

The third section involved a presentation by a local community member who described his experiences as a person living with HIV in the current legal context. This was followed by brief summary presentation of the day's proceedings.

Table 1: Participant Information

Descriptor	Category	Response
Identified Practice Domain	Nursing	31 (66.1%)
	Medicine	1 (2.1%)
	Social Work	2 (4.2%)
	Law	2 (4.2%)
	Other	11 (23.4%)
Length of Practice	Total	0-40 years (mean = 15.7 years)
	In HIV/AIDS-related care	0-23.5 years (mean = 8.0 years)

Figure 1: Invitation Poster

Université d'Ottawa | University of Ottawa

CRIMINALISATION DU VIH ET PRATIQUE INFIRMIÈRE
HIV CRIMINALIZATION & NURSING PRACTICE



2011.10.28

Hosted by | Hôtes

Patrick O'Byrne, RN PhD & Marilou Gagnon, RN PhD



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Part 2: The Current Context

In this section, brief summaries of the four main speakers are provided. These include (a) the criminal law in Canada, (b) relevant public health legislation in Ontario, (c) civil legal considerations, and (d) professional nursing standards in Ontario. Each of the descriptions provided here is a slightly expanded overview of the material that was provided by the keynote speakers.

The Criminal Law

At present, there is no criminal legislation in Canada regarding HIV transmission or disclosure.[2,3,5] There are legal precedents, however, the first being the *R. v. Cuerrier* Supreme Court of Canada ruling in 1998.[5,18] This court decision, which found *Cuerrier* guilty of aggravated sexual assault, established that people living with HIV must disclose their serostatus prior to the onset of any activity that poses a “significant risk” for HIV transmission, and that

failure to do so constitutes a sexual assault, provided that the consent to sexual activity that was given would have been withheld had the person living with HIV disclosed his/her serostatus.[5,18] This ruling established a few important points. First, it identified that the issue relating to serostatus disclosure under Canadian law is misrepresentation. Serostatus disclosure in the potential event of exposure must occur because, according to the Supreme Court of Canada, withholding one’s HIV-positive serostatus constitutes fraud, and thus can invalidate the consent that was given for sex.[5,18] Consequently, HIV transmission is not required for prosecution or conviction in these proceedings.[5,18] Second, this legal decision signaled that, according to Canadian legal precedent, the incurable nature of HIV makes its transmission an assault that causes bodily harm; this ruling was made in 1998.[5,18]

Further ambiguity exists in this ruling because, in the 1998 *R. v. Cuerrier* decision, the Supreme Court failed to establish a clear description of “significant risk”, and consequently, judges have been forced to interpret this term on an

individual basis.[1-6] Problematically, these judges have not always interpreted the *R. v. Cuerrier* ruling consistently, or in a manner that reflects scientific literature.[1,2,5,6] For example, a man was acquitted by the Manitoba Court of Appeal because he carefully used a condom when his viral load was high, but had unprotected sex when his HIV viral load was undetectable; meanwhile, in Ontario, a man was convicted for serostatus nondisclosure for protected intercourse and unprotected oral sex.[5] In each case, the respective provincial courts interpreted “significant risk” in strikingly different ways. The fluctuating interpretations of “significant risk”, coupled with the fact that some of these interpretations do not reflect scientific evidence, have consequently created a situation of confusion for many health care providers: for example, What constitutes “significant risk” for the purpose of the criminal law?[1,5,6]

The second important Supreme Court of Canada serostatus nondisclosure case is *R. v. Williams*,[20] which added to the *R. v. Cuerrier*[5,18] decision that a definitive HIV diagnosis is not required for the imposition of a legal serostatus disclosure obligation. In this 2003 decision, the Supreme Court added that “once an individual becomes aware of a risk that he or she has contracted HIV, and hence that his or her partner’s consent has become an issue, but nevertheless persists in unprotected sex that creates a risk of further HIV transmission without disclosure to his or her partner, recklessness is established”. [20] Accordingly, the *R. v. Williams* ruling introduced a serostatus disclosure obligation not only on persons diagnosed with HIV, but also on persons who “become[] aware of a risk” that she/he could be HIV-positive.[20] To date, however, all serostatus nondisclosure prosecutions in Canada—including the foregoing *R. v. Williams* case—have involved people who had previously been diagnosed with HIV.[5] In other words, the potentially expansive reach of this legal precedent has never been tested in any subsequent legal trials.

Public Health Legislation in Ontario

In Ontario, the *Health Protection and Promotion Act, 1990* establishes the parameters of public health practice.[15] Section 2 of this Act, specifically, dictates that one of the main purposes of public health departments is to limit “the spread of disease”. [15] They are, therefore, institutions which exist, in part, to promote and protect health by addressing the transmission of communicable infections. Pursuant to this Act, section 25 stipulates that, to accomplish this goal, an array of health care professionals (e.g., nurses, physicians) must report the identification and/or diagnosis of certain

communicable diseases—known as reportable infections—to their local medical officer of health.[15] In Ontario, HIV is one such reportable infection.[15]

Another important section of the *Health Protection and Promotion Act, 1990* is Section 22, which authorizes local medical officers of health to instruct designated persons to take, or to refrain from taking, any action that is specified in the order.[15] These directives are in writing, and specify the actions that must be taken to diminish communicable disease transmission: for example, these orders can either mandate treatment (if available), or can proscribe the occurrence of certain practices, such as, unprotected sexual practices for people living with HIV. Section 22 orders are not limited, however, to situations of potential communicable disease exposure.[15] They can also be used if an individual refuses to take a prescribed treatment that would cure, or eliminate the infectiousness of, his/her communicable disease.[15] This scenario exists because Section 34 of the *Health Protection and Promotion Act, 1990* stipulates that physicians and nurses must also inform the local medical officer of health of instances when patients fail to comply with treatment directives.[15] The relationship between Section 22 directives and treatment directives for HIV have not, at present, been tested.

Moreover, Section 22 orders can also require a person to submit to examination and to deliver the findings of this assessment about his/her communicable disease status to the local health unit.[15] Section 22 orders can therefore be issued if, or when, a person who is identified as having been exposed to a communicable disease refuses to undergo testing to determine the presence of the communicable disease of concern; for example, a Section 22 order could be issued if a previous sexual contact of a person who was recently diagnosed with HIV failed to undergo HIV testing after she/he had been instructed to do so by the local health unit.[15]

Notwithstanding the broad scope of a Section 22 order, these public health directives can only be issued when three main conditions are satisfied: (a) a communicable disease exists or may exist; (b) the communicable disease presents a risk to the health of the community; and (c) the stipulations of the Section 22 order are necessary to decrease, or eliminate, the risk to community health that is presented by the communicable disease.[15] Furthermore, a Section 22 order cannot be written if a Section 35 detention order has already been given to the person of interest. These orders, therefore, can only be used in specific instances.[15]

Lastly, in the event that a medical officer of health issues a Section 22 directive and then acquires evidence (through any of the aforementioned means) that the order has been breached, the medical officer of health may then, under Section 102, apply to a judge of the Ontario Court of Justice to request that the courts “prohibit [the] continuation or repetition of contravention” of a section 22 directive.[15] During this application, the judge can ratify the Section 22 order as is, can modify it as she/he wishes, or can reject the motion.[15] This means that the judge can make the order more, or less, severe, or can outright dismiss the request. If the judge opts to maintain the order, the Section 22 directive becomes a court order.[15] Failure to comply with this court directive is a criminal offence.

Civil Law

Health care providers, including nurses and physicians, face challenges arising from the possible imposition of civil liability, i.e., a court order that one person pay damages to another, in these circumstances. One topic of particular interest is the concept known as the “duty to warn”.

The duty to warn is part of the law of negligence. A plaintiff seeking to prove negligence by a nurse or physician must prove four elements: (a) that the nurse or doctor owed that person a duty of care; (b) that the nurse or doctor’s conduct breached the standard of care; (c) that the person suffered damage; and (d) that the damages was caused by the nurse or doctor’s breach of the standard of care.

It is unusual for a court to decide that a nurse or doctor owes a duty of care to someone who is not their patient. Where a patient presents a clear risk of harm to an identifiable person or persons, however, such as an HIV positive patient who is involved in risk-bearing activity presenting a significant risk of transmission to an unsuspecting partner, it is possible that such a duty of care may be imposed.

Where the duty of care exists, the key question for practitioners is what standard of care the nurse or doctor would be required to meet. This is a complex question given the competing duty of confidentiality that nurses and doctors owe to their patients. It is important to recognize, however, that the standard of care is not one of perfection: nurses and doctors are required by courts to exercise only the degree of care and skill that could reasonably be expected of a prudent practitioner of the same experience and standing. The question to be answered, therefore, is what a reasonably skilled nurse or doctor do in the same circumstances?

Courts will generally consider evidence from the following sources to answer this question:

- Relevant legislation:
 - The Regulated Health Professions Act (Ontario) and related professional acts and regulations establish basic expectations for nurses and doctors including importantly, obligation to act in accordance with relevant professional standards and their duties of confidentiality to their patients;
 - The Health Protection and Promotion Act places reporting obligations upon nurses and doctors in relation to communicable diseases such as HIV infection that, in turn, enable public health authorities to fulfill their responsibilities to prevent the spread of disease in Ontario;
- Institutional policies and practices (e.g. when the nurse or doctor works in an institution such as a hospital or public health unit) may direct the conduct of practitioners in a given set of circumstances or limit the choices open to them;
- Professional practice guidelines may also be an important source of information for the court to consider, as these will often help “flesh out” the steps to be followed and factors to be considered by nurses and doctors when decision-making in the clinical context;
- Expert opinion from another practitioner or practitioners of similar skill and training as to what constitutes accepted standards of practice in the circumstances at issue is always important, and may include the need to consider competing policy objectives; arguments that a nurse or doctor had a “duty to warn” a third person, for example, raise important policy concerns that the court must understand and weigh carefully since imposing a duty to warn will amount to compelling the nurse or doctor to breach his or her obligation of confidentiality to their patient in circumstances where maintaining that confidentiality may be vitally important to a continued relationship with the patient and may in and of itself give rise to civil litigation and disciplinary action pursued by the patient for breach of confidence.

Whether a nurse or doctor has a “duty to warn” in order to attempt to reduce or prevent the risk of HIV transmission from their patient to another person or persons in any given set of

circumstances is not a question to which a “black and white” or “cookie-cutter” answer can be given. It is a judgment call that must be very carefully exercised considering all of the relevant factors and with a view to minimizing, as much as possible, any infringement on the confidentiality of the practitioner-patient relationship.[4] Unfortunately, the current resources available to help practitioners problem-solve in these difficult circumstances are very limited.

As a general rule, community-based practitioners are probably best advised to turn to their local public health authorities for assistance (and to seek legal advice) before undertaking any independent effort to warn a third party believed to be at risk of HIV transmission as a result of the conduct of a patient. (See Footnote below.) Even within health units, however, resources in the form of existing guidelines as to how to approach difficult cases or practical experience with such cases may be lacking.

What would be most helpful, therefore, is a broad-based effort to develop professional practice guidelines that would guide decision-making by nurses and doctors in difficult cases, in a manner that is minimally intrusive of the interests of patients living with HIV and receiving care while at the same time serving to protect public health. It is essential that such an effort include participation from practicing nurses and doctors, people living with HIV, community-based organizations serving people living with HIV, public health authorities (including both health units having greater and less experience with such cases) and others.

Professional Nursing Standards

In addition to the legal contexts of the criminal, civil, and public health laws that surround HIV, there are specific constraints that affect the professional practice of health care providers who work with people living with HIV/AIDS. First, since the *R. v. Cuerrier* and *R. v. Williams* rulings,[18,19] prosecutors have begun using the documentation produced by HIV/AIDS practitioners to obtain convictions against people living with HIV.[4] Health care notes are deemed ideal because the courts believe that these writings are

accurate and veritable.[20,21]

Second, in Ontario, many health care providers are designated in, and controlled by, the *Regulated Health Professionals Act, 1991*—a piece of legislation which identifies the scope of practice for nurses, physicians, and other health care professionals the parameters which constitute professional misconduct for these groups, and the legal power that is granted to their respective professional organizations (e.g., the College of Nurses of Ontario and the College of Physicians and Surgeons of Ontario).[22] For nurses and physicians, each of the respective foregoing institutions enforces the registration, discipline, and quality assurance programs for its members.[22] Additionally, under the authority of subsequent legislation (e.g., the *Nursing Act, 1991*) that arises from the *Regulated Health Professionals Act, 1990*, respective Colleges establish practice standards.[22-23] According to the College of Nurses of Ontario,[24] these standards are “authoritative statement[s] that set[] out the legal and professional basis of nursing practice” in Ontario. Professional standards, therefore, are not simply guidelines that help structure practice; instead, they are “expectations that contribute to public protections, [and which] ... inform nurses of their accountability and the public of what to expect from nurses.”[24]

In the current context, one relevant nursing standard is entitled *Documentation, Revised 2008*,[11] which identifies that nurses must note in patients’ charts any and all details that are important to the plan for, and continuity of, patient care. This means that, in public health and, especially, sexual health practice, health care charts should indicate the types of sex practices a person has engaged in, and/or if any forms of protection (e.g., a condom) were used during previous sexual activity. Charts should also include test results. This information provides relevant clinical information that was acquired during assessment, and suggests the plan of care and any other relevant interventions.[11,25] In relation to HIV, depending on the practice area and patient needs, the standard of care could include information about HIV transmission, testing and/or treatment modalities, and disclosure obligations.

FOOTNOTE: Section 34(1) of the *Health Protection and Promotion Act* states: “Every physician and every registered nurse in the extended class shall report to the medical officer of health the name and residence address of any person who is under the care and treatment of the physician or the nurse in respect of a communicable disease and who refuses or neglects to continue the treatment in a manner and to a degree satisfactory to the physician or the nurse.” Aside from the practical assistance public health authorities may offer in such circumstances, a nurse in the extended class or physician who makes a report to public health authorities as required by section 34(1) may be protected from related legal action for breach of confidence by section 39(2)(0.a) of the Act. Nurses and doctors working within health units and acting in good faith are also protected from legal action by the Act (section 95).

Problematically, prosecutors use these notes to determine if a person is aware of his/her serostatus disclosure obligations, and if she/he was provided with adequate information to understand HIV transmission.[4] Complicating this situation is the fact that, not only can these notes support prosecutions of people living with HIV, they can also substantiate civil litigation against health care providers.[4] Consequently, health care providers must document items that, on the one hand, could harm their patients if criminal prosecutors were to obtain these documents, and on the other, might expose these same health care professionals to potential accusations that they failed to provide appropriate care (e.g., allegations that a nurse failed to meet the standard of care).[25]

Fourth, as noted above, in Ontario, for infection control purposes, the *Health Protection and Promotion Act, 1990* requires certain health professionals transmit information about the identification and/or diagnosis of specific communicable infections to their local Medical Officer of Health.[15] That is, public health legislation mandates nurses and physicians to report specific information about identified and diagnosed infectious diseases, such as HIV, to local public health nurses.[15] The goal is to allow this second group of health professionals to ensure appropriate treatment, follow-up, and notification of other persons who may be unaware that they were exposed to a communicable infection.[15] This legislation thus places legal obligations on two groups of health professionals: First, those who undertake front-line clinical practice and identify, and/or diagnose HIV infections, must report these diagnoses to the local public health department; second, public health nurses and physicians must then ensure appropriate follow-up for persons diagnosed with HIV and their sexual, or injection drug using, partners.[15]

Problematically, in some ways, this public health notification and follow-up process hinders patient confidentiality, and produces a public health department record of the outcomes of certain tests and treatments. In relation to certain situations of serostatus nondisclosure, this process has implicated local health departments and their employees as witnesses in criminal cases and defendants in civil cases.[4]

Fifth, health care providers, as paid employees, must respect their employment contracts.[26] This relates, in part, to vicarious liability, in which employees are covered by their employer's insurance provided that they follow institutional policies.[27] Consequently, health care providers are required, in many instances, to engage in practices that protect their employer. This is a unique challenge faced by health care providers (more so nurses than physicians), and

has not yet been addressed in the extant literature.

In summary, for health professionals—specifically nurses—the outcome of the current legal context is that their practice, including that related to documentation, arises from an array of varying, and at times, conflicting legislation. In real-life, these laws impact on professional standards of clinical assessments, planning, interventions, and evaluations (known as the nursing process), organizational policies, procedures, and decision support tools. Complicating this scenario is that (in relation to front-line HIV/AIDS care) client needs and clinicians' desires to help their patients can be at odds with professional and other institutional efforts to protect themselves from civil litigation and criminal prosecutors' determination to obtain client charts for criminal proceedings. Thus, the interaction between health professionals and patients, particularly if these patients are living with HIV, is compromised by a series of laws that regulate what must be included in the provision of care, what must be stated to patients, and what must be documented about health care exchanges.

3



Part 3: The Meeting

Discussion groups were used as the primary source of data for this project. Nurses who participated in the event were assigned to discussion groups and met, for a period of 90 minutes, with a facilitator who was given a discussion guide, and had attended a training session prior to the event. The guide was prepared using three scenarios and a number of related questions. See Table 2 below for a presentation of these scenarios.

Each scenario was developed based on real-life cases, and captured the complexity of nursing practice in the context of HIV criminalization. A few questions were added to each scenario to help the facilitators achieve a better understanding of the participants' elicited narrative. Each facilitator used the guide to explore the complex experiences of nurses who attended the event and the reasoning behind their attitudes, beliefs, perceptions, and actions. The intention was to encourage nurses to question each other and to explain

themselves to each other, with a specific emphasis on the kinds of interactions that would expose the impact of HIV criminalization on nursing practice.

The discussion groups were structured in such a way that participants were given the opportunity to share personal thoughts and feelings, and to describe the challenges they faced as health care providers. Facilitators were asked to moderate the discussion to make sure that issues were explored in depth and that participant involvement was maximized. The facilitators were also encouraged to maintain the focus of the small group discussions on the effect of HIV criminalization on their clinical work, and on the ways the participants addressed this complex phenomenon in their daily practice. The information emerged from an in-depth analysis of the descriptions the participants provided about how and why they approached, and responded to, the pre-established clinical scenarios.

Each discussion group session was audio-recorded and transcribed. Transcriptions were analyzed using the

principles of thematic analysis. During the pre-analysis phase, each interview was transcribed, and then reviewed by the researchers. During the analysis phase, each interview was read for emergent themes and these were coded. This codification process facilitated the analysis, and allowed the

researchers to regroup specific issues into larger themes as they were identified. The following section focuses on the four main findings that summarize the participants' narratives.

Table 2: Small Group Scenarios

Table 2: Small Group Scenarios	
Scenario 1	
	32 year old male patient at clinic for routine follow-up. Diagnosis with HIV 7 years ago. Client overall healthy today. Vitals as noted. Asymptomatic today. Client notes history of unprotected sex since last STI testing. Client reports that all sexual partners are male. Client agrees to gonorrhoea, chlamydia, and syphilis testing. All tests performed. Client counselled regarding window periods, positive result follow-up, safer sex practices, and HIV disclosure.
Scenario 2	
	A 43 year old female patient, who was diagnosed with HIV approximately ten years earlier, attends a clinic to complete the third dose of her hepatitis B vaccination. During the vaccination, the patient mentions that she has recently started a new relationship. She states that she had a protected sexual contact with this new partner last week. She also reports that she did not disclose her HIV serological status to this partner because she did not feel comfortable doing so at that time. This patient then requested advice about what to do in the future if a condom breaks during sexual contact.
Scenario 3	
	A 17 year old female patient presents to a clinic. When asked for her reason for attending the clinic, she reports that she had an unprotected vaginal and oral sexual contact with a casual partner; the contact was two days ago. She also states that after this sexual contact with this casual partner, she found a medication in his bathroom. She reports that she asked the partner about this medication, and he then disclosed that he is HIV positive.

4



Part 4: Findings

As noted above, 47 individuals, of whom the majority were nurses, participated in this event. In the afternoon component of the event, these individuals were assigned to eight small groups that were audio-recorded and analyzed. The results of these discussions and the ensuing analysis produced four main findings that addressed HIV status disclosure, counselling about such disclosure, the role of nurses in discussing legal issues, and the perceived effects that such counselling and documentation thereof could be having on the nurse-patient relationship.

Finding 1: “As per *R. v. Cuerrier* and *R. v. Williams* decisions, disclosure discussed”

The findings of this project demonstrated two main points. First, our participants’ statements demonstrated that they were clearly familiar with both the 1998 *R. v. Cuerrier* and the 2003 *R. v. Williams* decisions. Second, the participants

noted that these decisions have changed the way in which they address the topic of serostatus disclosure in front-line practice. Based on the participants’ statements throughout the discussions about serostatus disclosure, it appeared that, in the current context, disclosure is primarily seen as a legal duty which relates to the risk of prosecution. One nurse’s comment exemplifies this sentiment:

I would talk to her [female patient] just about the present context that you could be in big trouble if you don’t disclose and then a condom breaks and then the person suddenly finds out. And [I] frame it in the sense that, in order to protect you from legal action, this could be problematic.

As summarized in the previous statement, the majority of the participants considered that disclosure has a strong “protective” effect against the risk of prosecution and the risk of HIV transmission. For this reason, many of the participants viewed disclosure as an activity that is inherently beneficial for both people living with HIV and the general community. Another participant explained how this “protective” effect shapes discussions about disclosure with their patients:

I'll say, 'I want you to protect yourself from... So, that's my reason for you to disclose. ... Because I don't want you to get in trouble.'

Notwithstanding many of the participants' belief that disclosure provides a "protective" effect, some participants questioned the association between serostatus disclosure and legal protection. As suggested by the following participant, the outcomes of disclosure may not always be positive or desired:

But does it save them from being in trouble, disclosing? ... I feel that they're more at risk once they're disclosing.

Moreover, comments by other participants indicated that they do take on the responsibility of informing patients about their legal duty to disclose even though they noted at other times in the discussions that they are not the professionals who are equipped to address the meaning, significance, and threshold of this legal duty. Thus, while our participants recognized that the responsibility to discuss legal issues falls outside their area of expertise and scope of practice, they nevertheless reported that discussing issues related to serostatus disclosure/nondisclosure is part of their job. One nurse-participant succinctly summarized this contradiction between discussing the legal aspects of serostatus disclosure and knowing that one is not the appropriate person to be discussing such components of law. She stated:

As a nurse, I don't know necessarily all the legal precedents. I don't know necessarily what kind of assault this could be. So, I mean, my job is to tell her, like you said, Williams, Cuerrier. This is what people living with HIV are told. This is what disclosure is. But there is the component of significant risk. And there is the component of assault. And you might need to explore that with somebody. And I'm not necessarily the best person. Right? Because we're not.

Embedded within the above participant's statement are two contradictory desires: On the one hand, she felt impelled to discuss significant risk and serostatus disclosure as a nurse ("So, I mean, my job is to tell her ... Williams, Cuerrier ... significant risk and ... assault."); while on the other hand, she acknowledged that she has limited knowledge of these aspects of law, and is therefore, "not necessarily the best person" to be providing such information because she "do[es]n't know ... all the legal precedents". This participant, whose statement summarizes a commonly raised point in the group discussion, thus described a conflict between wanting to ensure that patients know the HIV-related legal precedents and recognizing that nurses are not ideal for this situation.

Two other participants' statements reinforced this finding; they stated their wishes to forewarn patients about the

legal implications of serostatus nondisclosure even after stating how discussing such legal information with patients was neither an easy, nor straightforward task. These two participants described the conflict as follows:

I would feel that I'd want to mention something about disclosure and what the ramifications could be to her, without scaring her, [or] breaking down the trust in the relationship, but also [while] having her be able to make informed decisions.

I would also maybe provide literature. Because I can't offer you [i.e., a patient] any type of legal advice. All I know is that there are risks associated with different activities. And if you have further questions about your legal responsibilities, you should consult this. Disclosure is not easy. It can take a long time before you become comfortable with it. But just be aware that you could be putting yourself at legal risk without disclosing.

As is clear in the two previous excerpts, most of the participants did not feel comfortable interpreting and discussing the contemporary legal context as it relates to serostatus disclosure. In this regard, participants mentioned that it has become extremely difficult for nurses to provide, what has been defined here as, 'disclosure counselling': the process of having patients express difficulties with serostatus disclosure, sharing personal experiences and concerns, asking questions, and receiving the support they need to communicate their serostatus to a sexual partner, a friend, a family member, a colleague, and so forth. Disclosure counselling is, therefore, also a key opportunity for nurses and other health professionals to assess patients' learning needs regarding sexual practices, and to provide education as needed. However, participants in this project described how disclosure counselling—which is supposed to benefit the patient who is living with HIV and who is requesting care—has become increasingly challenging in the current legal context. One participant stated:

And, sometimes, it's awkward around disclosure. I've had kind of what we alluded to earlier, where people are saying they don't disclose because it's a bathhouse and it's, you know, at your own risk. But I mean, at least, I'm visiting it. And I always tell my patient, I will say, 'You know what? I'm a nurse and I work for you. I'm not the police. I'm not legal counsel. I just want to know because I want to make sure that you're healthy.' And, yes, my role is first and foremost always to the client.

As noted by the previous participant, serostatus disclosure is a complex process that must be understood as such. Indeed, the foregoing participant's statement exemplified a sentiment that was common among the participants: nurses should consider the reasons why someone who is living with HIV

might not, or might be unable, to disclose his/her serostatus at a particular time: for example, as a result of fear, rejection, violence, et cetera. As part of this finding, participants noted that nurses, in trying to understand why someone might not disclose within a particular context, should provide assistance to their patients as needed. Our participants emphasized that, first and foremost, nurses are responsible for providing care to their patients; they are not supposed to engage in law enforcement. Another participant takes this point further:

I just think bringing the legal system into the healthcare system, there's just bound to be so many conflicts between the two. And it's just frustrating trying to bridge that gap. We're still providing patient care. I mean, our number one, you know, responsibility to the patient, not the legal system.

Awareness of the interface between the legal and the health care systems was strongly conveyed by participants. Findings indicate that this intersection—whether real or perceived—made nurses uneasy about their role and responsibilities, especially regarding disclosure counselling. One participant stated:

It's too bad, because I agree that we should encourage it [HIV disclosure], but I feel that I'm not the one who should be enforcing it. ... That's the part that I don't like.

In the above, the participant differentiated between encouraging and enforcing serostatus disclosure. She felt that the former is part of nursing practice, but the latter is not. Thus, findings suggest that most of the participants are confused/conflicted about serostatus disclosure requirements and their appropriate involvement in this topic. However, not all participants shared this confusion. Some considered that their nursing role included a responsibility/duty to ask patients about disclosure, to reinforce the legal duty to disclose, and even to question patients about the occurrence of disclosure; in other words, some participants noted that it is their job to engage in a form of law enforcement about serostatus disclosure. Four quotations demonstrate this point:

I have to ask John, 'Did you discuss [disclosure] with Mary?' And, you know, I have to ask and I don't want to risk them never coming back for services. So, I have to find a nice way to ask. [emphasis added]

I think you just... like, my mind would be more like, you know, you just have to just say, you know, 'You notice that you have an STI. So, obviously, you're having unprotected sex. I just need to reinforce with you, however, that you're supposed to [disclose], you know.' [emphasis added]

Another question that came up this morning I thought of was that if I had, if someone is HIV positive and

they've been HIV positive for 7 years, 10 years, and they come into clinic and they're getting tested for chlamydia or gonorrhoea, so, well, what does that mean? Again, what does that mean? Maybe it means that it's consensual. Maybe it means that they're not disclosing. So, it is my duty to investigate. [emphasis added]

Yes, so, when you talk to someone with HIV, you do revisit disclosure with them. Like, in this case, you would bring up, like, 'Have you disclosed to these partners?' [emphasis added]

Clearly, these four excerpts contradict the feelings of the previous participant who noted, "I'm not the one who should be enforcing it [i.e., serostatus disclosure]." -- a contrast that highlighted the differences of opinion that existed on this topic among the participants.

Further analysis of the participants' statements revealed that, in the local context, workplace and institutional policies may be contributing to the role confusion that our participants described. To explain further, the participants noted that nurses are increasingly being asked to document that their patients have been made aware of their legal duties regarding serostatus disclosure, and to request that patients sign legal documentation of this to ensure lawsuit protection for health agencies and their staff. Two quotes demonstrate this finding:

We have [a policy]. Patients read a form. We discuss the form. We ask them the reason. We talk about window periods. We talk about HIV disclosure. We refer to Cuerrier. We do tell them.

Yes, that helps a lot. A form which you sign and they sign. And I think that's good as well because we're putting more responsibility on the client as well.

Underpinning the foregoing statements is the participants' reliance on the criminal law that surrounds serostatus nondisclosure in Canada. Such policies, which center on law enforcement and which require nurses to address serostatus disclosure from a predominantly legal—not health care—framework, were nevertheless criticized by a number of other participants. Issues were raised around the intent of these policies and their effects on patients as well as nurses. One participant argued that such policies shift the focus away from disclosure counselling, as described above, and may instead lead to nurses feeling as if they need to legally protect themselves. One participant stated:

I know it's kind of covering your ass. But, on the other hand, it's not helping get good advice either, right. ... 'Here's a form. You can navigate yourself.' Or, what I'm going to tell you is, 'Disclose to every single person you have sexual contact with. Those are your options.'

As evidenced in the previous quotation and those which

preceded it, the first finding presented herein encompasses the participants' ambivalent and diverse interpretations of how and why the criminal rulings in *R. v. Cuerrier* and *R. v. Williams* relate to their clinical practice. For some participants, discussing serostatus disclosure was seen as being beneficial to patients; by comparison, for others, these discussions were understood as being in the best interests of the clinicians and/or their respective institutions. For example, for the participant quoted immediately above, discussing serostatus disclosure occurs as a form of self-protection that does not necessarily benefit patients and people living with HIV, because, in many instances, such discussions may leave the person living with HIV to navigate the contemporary legal system without the appropriate support systems and information.

Finding 2: "I don't think I would talk about significant risk. I don't want to be responsible."

Further analysis of the participants' statements revealed that nurses have been engaging in disclosure counselling, including explanations about the legal threshold of significant risk, without having specific guidance and knowledge on this topic. Some participants insisted that the legal duty for serostatus disclosure applies only when there is a significant risk for HIV transmission. Others, meanwhile, distanced themselves from the test set out by the Supreme Court of Canada. As the participants worked through the scenarios, their statements revealed that some participants felt compelled, in clinical practice, to clarify, or at least revisit, the idea of significant risk with their patients. Again, this sentiment was not unanimous, and other participants stated that they preferred to have patients define what constitutes a significant risk for HIV transmission, and to determine for themselves when they have, or may have, a legal obligation to disclose their serostatus. The following excerpt from a group discussion exemplifies these varying approaches and beliefs:

P1: "But you're saying that she's supposed to disclose, but are you sure she's supposed to?"

P2: "Yes, I'm still going to counsel on disclosing. That hasn't changed."

P1: "But you're supposed to tell her when there's significant risk."

P3: "Yes, you're supposed to inform them what situation is supposed to disclose."

P2: "But significant risk, I mean, I guess what if she is..."

P4: "Oh, I don't know that I would get into that, because we can't define [significant risk]."

P2: "Exactly."

P4: "Like I don't even know... Yes, we can't define [significant risk]."

P2: "To me, it's up to that person to make that decision..."

The preceding exchange indicates that, although some nurses refer to the legal test of significant risk when they talk about serostatus disclosure with their patients, other participants noted that they are reluctant to do so because there still remains a great deal of confusion over the meaning, significance, and threshold of significant risk. Another participant echoed the generally held feelings of ambivalence about discussing significant risk:

For me, I just, I would just give her the advice about Cuerrier, and I'd have that discussion, that confusing discussion about significant risk.

Underpinning the participants' ambivalence toward the legal idea of significant risk that is exemplified in the foregoing statement, the majority of participants reported that they did not want to be responsible for interpreting and applying the legal test of significant risk in clinical practice. Nevertheless, because many participants felt that such discussions are a component of nursing practice, they reported the strategies they used to approach this topic, such as, recommending that patients both disclose their serostatus all the time, and engage in safer sex practices in all instances. Many of the participants believed that serostatus disclosure less than all of the time creates a situation wherein health care professionals would have to interpret the meaning and threshold of significant risk, and then counsel their patients accordingly. Participants described this scenario as being undesirable. One participant summarizes this sentiment:

There are all kinds of other things attached to the risk that's going on. ... And I don't like the proposition of determining for them if it [i.e., a specific sexual practice] was significant or not. So, I feel I would encourage [a] person to disclose to any partner.

Participants explained that they prefer not to go into the detail about risk and, instead, to encourage patients to disclose their serostatus in all situations where any chance of HIV transmission could exist. It was also believed that safe sex practices could not pose a significant risk under the law. Condom use, for example, was considered to be the best strategy to circumvent issues of significant risk:

We don't go into the detail of high risk, low risk. We tell them about condom use.

According to the participants, they did not want to be responsible for explaining the legal meaning of significant risk. Instead, they recounted how nurses will often provide

patients with written documentation (e.g., pamphlets) on the current Canadian law. This documentation can be helpful because it usually contains information on the subjects of significant risk and the duty to disclose. It may also refer patients to appropriate legal resources. One participant noted:

I would say ... 'that pamphlet or that booklet about HIV disclosure, ... you need to read it. It talks about significant risk and so on.' So, I mean, I think it's ... so that we are not the ones explaining all this.

In addition to using pamphlets as a strategy to discuss the legal meaning of significant risk for HIV transmission, the participants reported that nurses practicing in the HIV/AIDS domain work with the idea that risk varies based on an array of factors, including sexual activities, viral load, condom use, mucosal integrity, etc. The participants further described how some sexual activities are considered high risk for HIV transmission, some low risk, and others no risk at all. Along the same lines, participants also reported that an undetectable viral load and condom use can decrease the risk of HIV transmission. Two participants stated:

And just in terms of risk, and again, it could be purposely where it's just saying unprotected sex, but it doesn't say what kind of sexual activity. Is it high risk sexual activity? Is it lower risk sexuality? So, then, what would be the risk of transmission at that point? So, that for me is missing if we want to get like to actually assess that actual risk. So, is he receiving or is he giving? If he's giving, then, he's going to be exposing his partner to a greater risk of HIV transmission whereas the other way around is lower risk. So, that information for me, yes, if I was looking at it from nursing point of view wanting to look through all of that information, that would probably be helpful information to know the risk.

So, when the patient asks about what to do in the future if the condom breaks, well, clearly, she's taking the responsibility, like using protection. And the next question may be, 'Well, do you know if you have viral load or not?' You know, 'Is it detectable or not?' And if not, 'You, well, you know there's very little risk.'

Participants clearly referred to the public health understanding of risk in the way they commented on the different scenarios they were provided. They understood risk in relation to HIV transmission, and they assessed the possibility, or risk, of HIV transmission based on the extant scientific evidence and literature. Risk, accordingly, was located along a spectrum, from high-risk activities to low-risk activities. A participant described this point in relation to "varying degrees of risk". She stated:

Anytime I've been in a situation to give information, ... I don't necessarily think I've gone into detail around what's high risk and what's low, but I've

always explained that there's risk. And that it's varying degrees of risk.

While it is not evident in the foregoing quotation, it became quite clear during analysis phase of this project that the participants' understanding of risk was not completely detached from the legal interpretation of significant risk. In fact, the participants consistently overlapped the legal and public health interpretations in the group discussions. For example:

Well, there are different levels of risk. Some risk is higher than others. And we can't put absolute numbers on these risks. However, unprotected sex, for example, if a condom breaks would be considered higher risk, which could be interpreted as possibly a more significant risk.

Embedded within the majority of the participants' statements was an inextricable linkage between the public health understanding and the legal interpretation of risk. This point of contact, which can be summarized as high risk equals significant risk and vice versa, was evident in the ways the participants described/discussed risk, and in the manner in which they made sense of the current legal context. Therefore, whether legally accurate or not, for these participants, sexual practices that pose a high-risk for HIV transmission in the health care sense precipitate the legal duty to disclose, and can lead to criminal prosecution. Two participants stated:

If you say the table is zero risk, unprotected vaginal or anal is high, you lower your risk that much by using a condom. ... If the condom breaks, that ... to me, probably I would say that's a significant risk, and that she would have a legal obligation.

Unprotected sex leaves [a] person really open to legal action, because they could just, oh, assume it must have been the most ... risky type of sex.

In contrast to the apparent overlap between the public health and the legal interpretation of risk that the participants described above, a disconnection between these two understandings of risk was also evident in other statements. This second point emerged when the participants began to comment on some of the cases that have gone before the courts in Ontario, for example:

It was clear to me when they said that the courts are not clear. Then, how can we be clear? So, how could we counsel and make a judgment over risk, and then have it blow up in our face when we're like, 'Well, actually, that's not a risk at all.' And that case in Hamilton, wasn't that shocking? I don't think I've ever read that one, in Hamilton, that they were convicted and had used a condom with... or what is it, oral sex?'

While many of the participants conflated public health and legal understandings of risk, the foregoing statement clearly

demonstrated that, for some participants, differences do exist between the two interpretations. To explain further: the point of break between the public health and legal definitions of risk was particularly evident in the case described above because it relied on two types of sexual activities (i.e., protected intercourse and unprotected oral sex) that have traditionally been considered low risk by nurses. From a legal perspective, however, the Ontario courts considered these activities significantly risky for HIV transmission to charge and convict a man for serostatus nondisclosure. This specific case, among others, was used by the participants to both differentiate between public health and legal risk, and to highlight the considerable uncertainty that they feel regarding risk. The outcome for some participants was to explain to patients that any risk can be interpreted as significant risk in court. A participant stated:

The thing is you can tell them, 'You know, I understand you are responsible and I understand you want to protect yourself as well your partner. ... But, and although you're doing all of this, you have to know that every decision in court can be flipped... any side they want. So, it's never a sure case that, because you did all that and protected them to the best of your knowledge... there's no assured protection.'

In contrast to the foregoing approach to instruct patients that any risk could be interpreted as significant risk, other participants noted that, in fact, conflating all levels of risk undermines health care practices and HIV prevention and care efforts. One participant clearly summarized this point:

I think as a nurse, you can't just give the black and white, you have to get them and help them to make an important decision. So, they need to know, I think, the legalities. But also, from a healthcare stand point of view, low risk activity versus high risk activity: if you just talk about that all risk is risk, you're not giving truthful information to your patients by saying all sexual activity is high risk. So, I would have those discussions with the client, for sure.

Consciousness of the interface between the legal and the health care system was once more conveyed by participants. Findings indicate that this intersection is gradually transforming the way nurses understand risk, and convey information to, their patients. The concern here is that the legal construction of risk serves the function of a criminal law system, not patient education or public health practice.

Finding 3: "You're more conscious of the impact you may have when you document"

Because they were aware that the personal health records of people living with HIV could be used in criminal proceedings, the participants mentioned, on numerous occasions, that

they were increasingly concerned about their professional accountability in relation to how and what they document: that is, they were aware of the legal implications of nursing documentation, and knew that their notes could be used as evidence in the criminal prosecution of their patients. One participant stated:

But you know, I've been in this for 10 years and 2 years before that, but it never hits home like now because, maybe we have a few patients now that are in court. So, when you are requested to provide your chart... It's like, 'Oh.' That's when you start thinking of documentation, you know. Because, before, it was just normal. You document whatever you did, but in a broad sense.'

Many participants alluded to the fact that nursing documentation was never an issue in the domain of HIV/AIDS care until very recently. The fact that some of the participants have had their charts implicated in serostatus nondisclosure criminal cases (as noted in the foregoing statement), however, has changed the line of thinking of some of the participants when they document. Other participants agreed with the facilitator who suggested that "extra precautions" now need to be taken when documenting discussions on HIV disclosure and related concerns. An excerpt from a group discussion exemplifies this point:

P1: "Like you could make assumptions about that nursing note in your day-to-day. But, yes, if it was ever taken to trial, there are all kinds of loopholes in there. There are all kinds of grey area in those notes."

Facilitator: "So, you're saying that there would be a difference with HIV, so you take extra precautions..."

P1: "Because of the fact that there's criminalization."

In light of the current legal context, participants expressed uncertainty about what should and should not be documented regarding disclosure. As one participant pointed out, this uncertainty is new to nurses working in the field HIV. She stated:

Do you document or you don't? You know, I never asked myself that question before.

The above-noted quotation, in combination with the two which precede it, suggests that the participants were uncertain about documentation, in part, because they did not know what to document regarding disclosure, and, in part, because they were aware that their notes could (as stated in the next quotation), be used as evidence "against their patients". This perhaps explains why some participants were uncomfortable with the idea that nursing documentation could be used for purposes other than continuity of care and accountability. Another participant noted:

It's [i.e., the nursing document is] important for other people who will see the chart after because then you know that there might be some other counselling to do. But I feel, like, if you just discussed things together, it's not always necessary to write stuff like that. But, because some other people are going to be dealing with that person, then, it's important for them to have a history or to know... But I also feel that, if the person is HIV positive and you're writing stuff like that, it could be used against them.

In addition to the foregoing belief that nursing notes could be incriminating for patients who (a) express difficulties with or share concerns about the disclosure of their serological status, (b) during the clinical encounter, report unprotected sex, or (c) undergo testing for sexually transmitted infections (STIs); other participants believed that nursing notes could "benefit" or "protect" patients who reported that they engage in protected sex (or low-risk sexual activities) and/or who appear to, or report that they, "respond well" to disclosure counselling. Two participants' statements concisely summarize this finding:

So, yes. If it was relevant, I would document, because it would actually protect her again. So, she's using condoms. She knows that she needs to. So, the only thing that she's not doing is disclosing. We talk about disclosure; we're giving her strategies to disclose, telling her about the benefits of disclosure. And I would write that the client states she will disclose to partner or she'll make an appointment with an NGO or she will send an InSPOT card. [emphasis added]

I mean, because, yes, because this, even going back to when we were talking about legal, the legal aspects of documentation protecting your patient, right. I mean, if unprotected sex is unprotected receptive oral sex, say, and the patient responded really well to this disclosure conversation, then, that's really positive documentation in his favour.

Notwithstanding some participants' beliefs about the beneficial or detrimental effects of documentation, a third group of participants were ambivalent about the relationship between nursing documentation and legal outcomes. In other words, they were unsure about the actual impact of nursing documentation, and recognized that nursing documentation could have both beneficial and detrimental effects in the context of criminal prosecution. As one participant suggested, "where to draw the line" as a nurse is difficult. She stated:

And I find this all very interesting and conflicting also between... Like, I have issues around. So, you're right, sometimes, people will document, it'll benefit the client, in some cases. In other cases, it might not benefit the client. There are always two sides of the coin in there, right. And there are also issues around, you know. So, where do you draw the line? Do I say they're not disclosing when they're having oral sex unprotected? Because we know there's negligible

risk around that, right?

This excerpt, in addition to asking "where to draw the line?", encompasses questions that other participants were also raising: for example, What to document? How to document? When to document? Analysis of the participants' statements, however, revealed that these questions had little to do with continuity of care or accountability: that is, these questions were wholly unrelated to both patient care and nursing practice. Instead, the questions related to legal aspects that surround serostatus disclosure/nondisclosure. This was particularly evident in participants who questioned the need to document information that would indicate that a patient either is not disclosing his/her serostatus, or has not disclosed his/her serostatus to a sexual partner in previous instances. An excerpt from a group discussion highlights this point:

Facilitator: "Would you put in your notes that she had protected sexual contact?"

P1: "She said she had, I would put that she said she had protected sex, I would look at how did that go."

Facilitator: "Yes, and she asked if the condoms break, what should I do?"

P1: "Yes."

Facilitator: "You would put that in the notes?"

P1: "Oh, absolutely, I would, yes. I would, because, I would put that client states to have protected sex... patient's partner unaware of status? I don't know. Because... I don't know. Because, you know, that sounds harmful."

The above exchange indicates that, according to our participants, some nurses may refrain—or at least consider refraining—from documenting specific information that they perceive to be "harmful" or "incriminating" for their patients living with HIV. With this in mind, they may leave some information out of the nursing notes. This documentation practice was questioned, however, by a number of participants, who argued that this selective documentation practice could cause more harm than good. One participant explained this second sentiment:

If we look at it where someone had said, 'If this was taken to court and it was... any of our information ever help our client, would that information missing then be a... like harm our client because we didn't put it in?' That was lower risk behaviour, but, because we didn't write it in there, the person could have said, 'Well, actually, it was high risk behaviour.'

As they worked through the scenarios, a number of participants acknowledged that documentation practices should neither be guided by the criminal law, nor changed in response to criminal prosecutions. They felt that nurses should always

document in accordance with professional standards. As suggested by the next participant, documentation practices should remain grounded in a nursing perspective, and should reflect all aspects of the nursing process (including assessment, planning, intervention, and evaluation):

If she says, 'Listen, I want advice because the condom broke and I didn't disclose', if I don't chart that, then, that's because I'm thinking about HIV criminalization and I'm thinking what legal implications might she face in the future. But really, if I want to just keep my nursing cap on, then I would write, 'Client requested information because condom broke with this encounter. Nurse provided information.' You know? Like, I wouldn't hesitate, because, otherwise, you know, I would be giving into that whole sensationalization about what if something happens to her.

In the above, one participant described a common sentiment that was expressed by many participants: that nurses should not attempt to determine what information could lead to positive or negative legal outcomes. As part of this, the same participant expressed her belief that documentation practices should not be based on the legal interpretation of information shared during the clinical encounter. In fact, the majority of participants believed that nurses working in the field of HIV are not in a position to determine what information could potentially be used against a patient in criminal proceedings. The following excerpt from a group discussion explains this point further:

P1: "... documenting based on, 'Well, this could be used against them, but maybe it won't. So, I'm not going to add this or I'm going to add this'."

P2: "Because that's not what nursing's about."

P3: "Because that's not our decision."

P4: "I would write: 'States she's not comfortable disclosing at this time. Has only had protected contact. Requesting information on what to do in future if condom breaks during sexual contact'."

P5: "I find that that might be incriminating though, because what..."

P2: "That's not my job to decide."

P5: "I know, but do we have to... This is the same question I keep asking. It's like: Do I have to write what her specific question is?"

P2: "Why would you not? What would be the reason for not writing it?"

P5: "I just wonder if like... Like, I understand the need to write it. But I also wonder if it's a fine line between like too much information and then, you know, 'Client has questions around like condom use and disclosure'."

Overall, the participants considered that any decision

regarding nursing documentation should have a strong relationship with the plan of care, not the criminal law. As they worked through the scenarios, participants applied this standard consistently. Yet, there was no consensus among participants about the relevance of disclosure to the plan of care. It was, at least for some participants, obvious that information on disclosure, or nondisclosure, is relevant to the plan of care because it provides an accurate, clear and comprehensive picture of the patient's needs as per the College of Nurses of Ontario's practice standards. This information was also considered relevant to the implementation of nursing interventions, especially when working with patients who might be "struggling" with disclosure. One participant stated:

They'd say as well in our notes when we talk about this, we can say, 'Patient is struggling with disclosure in the sense that, you know...' Like, does she say she's...? That's part of the care plan is to support her to go through this.

However, a number of participants did not agree with this rationale, and stated that disclosure/nondisclosure was not considered relevant to the plan of care for a number of reasons. The main reason that was put forward to demonstrate the irrelevance of this information was that this information may not affect or change—and thus be relevant to—the actual care that a patient needed, needs, or will need. Participants explained that they would not "approach things differently" based on such information, meaning that this information would not alter the plan of care. Two participant statements illustrate this finding:

I feel that it wouldn't change if he said he wasn't disclosing, for me, because... Well, depending, it's always depending the context of the... if he's with one regular partner and that partner doesn't know, you know, for a certain period of time, or if he's having, you know, multiple partners. Then, I feel like it's kind of like, it's kind of a given, well, reality that you don't always disclose when you have multiple partners, and that is not always necessary if you're having protected sex for oral... not oral, but in all events, no. So, I don't think it would be part of my plan of care.

Like, whether you would approach things differently or not. Because, even if this... meaning, you know, you would still give the same counselling whether she disclosed or not, I guess. So, your plan of care may not have changed. And I don't know if you had to document that she didn't disclose for the plan of care purpose, but you're being told more that you need to document this more from a legal perspective and your own credibility as a practitioner. And I think it's relevant to her sexual health as to what's going on, but is it relevant to the actual care you're going to give?

However, in contrast to the statements above, the two presented below indicate that other participants document discussions on disclosure to facilitate both continuity of care and plan of care. Nursing documentation is seen here, not only as a way to record a plan of care, but also as a valuable tool to support continuity of care and effective communication between health care providers. This finding was expressed when they responded to the scenarios:

That is one of the dilemmas that we're having in terms of our documentation. ... Is it our job to put that assessment in there? But, to me, I would want to know before I went in to do the next follow-up, if I'm seeing him again. It would be helpful to me to know where he was at that point with that information. And then, I could build on what was done.

But that's what I would have done. So that any other nurse or the doctor that came into our clinic could read the chart 'Oh, wow! That woman was dealing with all these things.' ... Even if she comes in for something else, they are going to know without her having to repeat all this over.

During the discussion groups, participants became acutely aware of their legal and professional accountability regarding documentation. They were concerned that their notes might one day be used in criminal proceedings and that detailed documentation was the best way to ensure that nursing notes are accurate and complete, especially in relation to disclosure. In fact, detailed documentation was generally assumed to protect nurses, and establish credibility in the courtroom. One participant stated:

You know, when we said about like the disclosure, whatever, and how we don't want to... we don't want to be punitive towards the client if ever this goes to court. But how are we going to be seen as credible if we didn't chart our concerns? How are you going to present yourself trying to explain what happened... if you left it out of your notes?

In addition to not looking credible, participants worried that they might be held responsible for failing to document certain information regarding serostatus disclosure. This point was clearly explained by the following participants:

Are you going to be held responsible if something happens, you know, like something else comes about? Are you responsible because you never charted that, because it was sort of, you know, 'Oh, by the way', you know, from the client? And you get that often. Often, they come up with things that have absolutely nothing to do with what they are doing at the clinic to begin with. And, then, you know, you're stuck with that information. Now, do you document that or do you leave it pass and, you know, hope nothing else comes about?

There are probably lots of staff with this ethical

dilemma every day, you know, trying to decide how they're going to document and worried about their own licence. I mean, this is our livelihood. And, in our practice, it's not going to be the same volume of clients, but I think that it's a very real concern that your, you know, your name, your licence, your job could be on the line for some kind of documentation, or misdocumentation, or no documentation plan. That, I think, is a big fear.

As a result of these concerns related to documentation, the majority of participants expressed that they need professional guidelines on nursing documentation that can be applied to HIV/AIDS care. Ideally, such guidelines would consider the current legal context, and would assist nurses in making decisions about documenting discussions related to serostatus disclosure. Such guidelines would also address the what, when, and how of nursing documentation as it relates to disclosure. Three participants explained:

So, I think having best practice guidelines to incorporate into each individual case could help documentation and the plan of care, too. I think it's not clear about what you're supposed to chart.

For the guidelines, what we should be documenting. Should we not be writing stuff about their partner or their discussions with us on their telling us that they're not using protection, or... You know what I mean? Are we incriminating them by documenting this?

Well, I guess it's clear that everyone wants some guidelines for how they should be charting and how they should be dealing with the patients. So, that's something that, hopefully, through the RAO [Registered Nurses Association of Ontario], we can have some guidelines.

Participants argued that nursing practice standards do not provide sufficient guidance to nurses working in the field of HIV and, as a result, they reported feeling unsure about their practice and their respective roles. This cannot be without effect on the delivery of nursing care.

Finding 4: "I feel there's a lack of trust"

As the final finding, the participants reported their belief that HIV criminalization has eroded patients' and the public's trust in nurses and other health care providers. Participants, furthermore, noted their belief that this phenomenon threatens the therapeutic relationship that enables nurses to provide optimal patient care, and therefore, that it interferes with health care practice. According to the participants, HIV criminalization consequentially hinders the effort to build trustworthy relationships and, in doing so, undermines the nurse's ability to provide a safe and open space for people living with HIV to discuss their concerns, whether these relate to serostatus disclosure, or not. This particular point

was discussed at length by participants:

I feel there's a lack of trust. You know, your patient tells you they don't want to explain, you know, tell anybody about their problem, like, you know, 'I'm HIV positive, but I don't want anybody else to know.' And then, because of some law somewhere around, you know, or some policy somewhere, you know, it says that we have to tell, which is, you know, you can see the good points of having to tell the partner or whatever. But, then, you've lost the trust of that patient that has said to you, 'You know, I don't want to disclose.' And so, how do you continue counselling or talking to that patient because they don't trust you anymore? I find that really difficult to, you know, I mean, yes, you documented it and, yes, you know, you consulted other people and, in practice, sort of thing, you know, that you work with... But the act of trust is gone completely. And so, therefore, your communication with that HIV patient is gone.

Which is why I think the public is sort of, you know, gets frustrated with Public Health. I mean, I don't know, I'm just suspecting that the community is frustrated with Public Health because they feel that we're still doing, you know, we're... Well, because we still get linked into the whole criminalization with the media, that we're feeding... the media information, that we're feeding the police information.

All this community sees, 'We're being charged, we're being charged, we're being prosecuted, we're being...' You know, I mean a lot of those things might be happening in other communities. But the media just has a field day if it's anyone from that [gay] community. And, you know, it causes further stigmatization for them in the community and outside of the community. So, I think... I mean, I don't know what the solutions are. The answers are there, but I think it's important to, when we're looking at people coming into the clinic for our services, to have that in your mind as well, because their lived experience coming in has that baggage. So, they might be, they might tell you they're disclosing, but they're not because there's a whole other baggage of fear that goes with them being targeted through the media and all these little things too.

According to the participants, patients may not trust that discussions about serostatus disclosure/nondisclosure will remain confidential, and not be given to the police (i.e., "feeding the police information"), or the media. Similarly, the participants believed that patients may not fully trust nurses because patients understand that discussions about serostatus disclosure will be documented, and that this documentation process creates a formal record of their practices that could be used against them if criminal proceedings are instituted. Another participant summarized this sentiment:

I was just thinking, say, for example, someone that had been living on the street but now they're doing a lot better, they're in supportive housing, but then they still have no friends or family in the area. So,

they have nobody to talk about the challenges they're facing, like disclosing. But then, they don't want to talk to the nurse who they usually trust, knowing that it could be used against them in court.

As is clearly stated in the foregoing excerpt, the participants felt that, in the current legal context, it has become difficult for nurses and patients to engage in a trusting, genuine relationship. Participants were concerned about the impact of criminalization on their ability to engage in "honest" conversations about disclosure, sexuality, and intimacy. They also reflected on how much criminalization affects patients' honesty during the clinical encounter. One participant stated:

You wonder how much that would inhibit the patient from being honest.

In a number of other instances, participants mentioned their belief that HIV criminalization may actually prevent people living with HIV from being "honest" and open with their health care providers. The following quotation summarizes this finding:

Well... So, they tell you that, they've disclosed that. But they don't know what the ramifications of that statement could be. And so how... what do you do with that information? I'm not suggesting I've been faced with that, but I think that, you know, patients don't know. I could say, I'm sure most people I know that aren't in the medical profession wouldn't realize that if they were... they would feel they're honest people. They would want to be honest with the provider. But, in turn, then, you know, they might be in, you know, a lot of hot water or be put in a situation that they absolutely didn't know that they could be put in.

The foregoing assumption that patients may not always be honest is important because it may create a situation of distrust where nurses seek information during clinical encounters and then question the veracity of this information. The fact that the participants alluded to the idea that patients are fearful of being open and honest with nurses and that they are consequently "dishonest", may affect the way care is delivered. Problematically, it may also undermine the quality of health care and nursing care services that a patient receives. Undoubtedly, the need exists for more discussions of this assumption and its impact on nursing care.

Summary: "I think that we're going to constantly be swimming in this grey zone"

Overall, participants explained that HIV criminalization has caused considerable uncertainty and confusion in their delivery of front-line HIV care. During the discussion groups, the participants reported the many challenges they face as they try to make sense of this uncertainty on a daily basis

and to provide nursing care to patients who experience firsthand the effects of HIV criminalization. As they worked through the scenarios, participants expressed the need for more guidance regarding the professional, legal, and ethical obligations that affect the care provided to people living with HIV and the way nurses address the current legal context in their practice. Participants mentioned that it has become extremely difficult and hazardous for nurses to determine safe and effective nursing practices when confronted by the widespread use of criminal law and its effect on the lives of people living with HIV. Specific concerns were raised regarding disclosure, risk, nursing documentation, nurse-patient relationship, and the fact that nurses are constantly navigating what appears to be a “grey zone” between health care and law enforcement. On multiple occasions, participants even explained that they were “swimming in a grey zone”. This was their way of describing, in their own words, the effect of HIV criminalization on nursing practice. Participants felt that it was important to get to the heart of this grey zone to make sure that nursing practice is neither tainted by criminalization, nor motivated by law enforcement ideology. The findings presented in this section may prove to be a useful starting point for an exploration of this topic.

5



Part 5: Discussion

While the participants disagreed both about whether or not nurses should discuss the meaning and threshold of significant risk, and about whether or not such discussions are in the best interests of patients, nurses, or health care institutions, it was clear from the participants' comments that the current legal context of HIV criminalization affects the practice of front-line nurses who work in HIV/AIDS care. Indeed, all of the participants who attended this event noted that nondisclosure prosecutions have made them reflect on, and, in some cases, change their practice: for example, by engaging in selective charting of patient histories and/or by undertaking purposive law enforcement practices related to serostatus disclosure. Most commonly, however, the participants noted that HIV criminalization has left them feeling unclear about the criminal law and the effect that this law has on their practice; that is, the participants noted that, in their front-line HIV/AIDS care practice, they are uncertain what to tell patients about serostatus disclosure, how to

raise the issue of serostatus disclosure, and if serostatus disclosure is even a topic that nurses should be discussing with patients. In summary, the participants reported a great deal of confusion about the criminal legal precedents surrounding serostatus disclosure in Canada, their roles in relation to these laws and serostatus disclosure, and how to appropriately document any/all interactions they have with patients that address serostatus disclosure. According to the participants, in some cases, this ambiguity undermines a nurse's ability to provide the appropriate and required care to patients living with HIV.

The ambiguity and confusion that the participants reported, however, is perhaps unsurprising when one considers the contemporary legal context that surrounds nurses who work in HIV/AIDS care. As noted above in *Part 2—The Current Context*, the framework which underpins current HIV/AIDS nursing practice is not only guided by professional standards and regulations, but also influenced by the criminal law, public health legislation, and civil liabilities, each exerting a distinct but interrelated influence on nursing care.[10-

15,22,23] For the participants in this project, the outcome of these various influences was two-part. First, they reported a profound sense of confusion related to nursing practice, nursing care, and the criminal law. That is, the participants questioned, what is the appropriate interface between these seemingly contradictory punitive and therapeutic processes? Second, the participants' statements revealed how their feelings of confusion produced two practical issues of ambiguity in relation to nursing documentation of serostatus disclosure, and the uncertainty surrounding the type of counselling that is both required and appropriate for HIV. In other words, the participants reported role confusion related to nursing practice within the context of varying—and, at times, conflicting—legal pressures that manifested for the participants as doubt about how, when, and what to counsel patients in relation to HIV, and how/what to document in patients' charts. According to the participants: what, if anything, should be written in a patient's chart about discussions they have had and the counselling they have provided about serostatus disclosure? Because this confusion produced varying perceptions of what should be written in a chart, issues surrounding the continuity of care could emerge. When one nurse documents in a particular fashion, and another, who may have a different opinion about the relationship between serostatus disclosure and nursing practice, reviews this material, misinterpretation could ensue. Consequently, subsequent clinicians may inaccurately interpret previous documentation, and may offer inappropriate nursing care.[25]

Presenting a greater problem, however, is the role confusion related to the participants' fear regarding their potential involvement in law enforcement activities – that is, the confusion related to serostatus disclosure and “significant risk” because this conceptualization of risk arises from legal precedents in criminal law, not public health practice or research.[1-3,5,6] In fact, in Canada, “significant risk” emerged as an item of importance in discussions of HIV transmission only after the Supreme Court of Canada used this measure as its legal test of criminal culpability.[1-3,5,6] In contrast, health care professionals, when discussing HIV transmission, have typically relied on the public health spectrum of risk, which ranges from no risk to low, moderate, and high risk.[10] Consequently, the participants in this project were both uncertain about, and of mixed opinion regarding, the relevance of information about significant risk for HIV transmission and nursing practice. Some participants identified that, when dealing with sexually active patients who are living with HIV, it is their job to inquire about, and

ensure that, serostatus disclosure occurs. Other participants, however, argued that nursing practice and patient care should not be dictated by the criminal law, and therefore, that inquiries about serostatus disclosure are irrelevant to nursing practice. A final group of participants suggested that discussing serostatus disclosure protects patients because it provides them with important information, and thus, allows them to be cognizant of the contemporary legal system. This last group of nurses appears to consider discussions about the criminal law and serostatus disclosure to be a standard nursing practice: that is, providing patients with the necessary tools—whether in the form of information or otherwise—that they need to deal with their health condition.

The role confusion that the participants experienced, however, does not simply highlight a lack of clarity in the practice of a few nurses. Furthermore, it does not relate exclusively to the selected nurses who reported such confusion. Rather, the role confusion that was identified within this project pinpoints a potentially larger issue in both the delivery of care for people living with HIV and in the practice of HIV prevention within the broader social context. More precisely, because the varying opinions held by the participants shapes how they provide frontline care for patients, some patients may be receiving varying forms of care and counselling in relation to HIV transmission and serostatus disclosure from different nurses depending on the nurse's interpretation of his/her role in the enforcement of serostatus disclosure and his/her understanding of how the legal test of “significant risk” relates to the public health conceptualization of probabilities for HIV transmission.

Some patients, therefore, might be told that any chance of HIV transmission constitutes a “significant risk”, while others might be instructed about the public health—not criminal law—interpretations of HIV transmission, and still others might not be given any information whatsoever about the risks of HIV transmission for fear that such discussions are based in law and not health care or nursing practice. Different groups of patients may thus receive (and base their sexual practices on) diverse interpretations of the risks of HIV transmission that are based on “significant risk” as defined by criminal law, not the extant scientific literature.[5] A previously quoted participant succinctly summarized this point: “You're not giving truthful information to your patients by saying all sexual activity is high risk”.

In relation to serostatus disclosure, it thus appears that both the inconsistencies in how Canadian courts have interpreted the legal definition of significant risk and institutions' desires to protect themselves from civil liabilities may have

inadvertently affected how some nurses educate patients on the practical risks associated with HIV transmission and the variables which decrease HIV transmission: That is, some of the participants noted how the ambiguity surrounding the Supreme Court of Canada's significant risk threshold caused them, first, to consider all risks as identical, and, second, to counsel clients accordingly (see Theme 2). For the participants in this event, such a scenario has arisen because of the lack of clarity about the relationship between the legal test of significant risk for HIV transmission and the public health measures of no, low, medium, and high risk. Disconcertingly, the implications of this situation could be far reaching: Some individuals—whether living with HIV or not—may be inadequately or inappropriately aware of the most efficacious and effective HIV prevention strategies. This situation, in turn, could undermine contemporary HIV prevention efforts and, likewise, could compromise the quality of life for people living with HIV. Because the findings presented herein simply raise these potential issues for discussion, further research is needed to evaluate, measure, and better explore the effect of nondisclosure prosecutions on health and health care, nursing and nursing practice, and public health outcomes related to HIV transmission.

6



Part 6: Conclusions & Recommendations

In closing, this report summarizes a full-day meeting that was organized to address, and better understand, the current context which surrounds nondisclosure prosecutions and nursing practice. In total, 47 participants attended the event, which consisted of large-group presentations and audio-recorded small group sessions. The presentations addressed: (a) criminal law and serostatus disclosure; (b) public health legislation surrounding HIV care and management; (c) the civil liabilities that can emerge when one provides HIV-related care; and (d) the professional regulations and standards that influence nursing practice. Thereafter, small groups focused on using this material to address three scenarios of HIV-related care. In these small group sessions, the participants described their feelings about counselling patients regarding serostatus disclosure, their uncertainties about the importance/relevance of “significant risk for HIV transmission” and nursing care, their ambivalence toward documenting exchanges about serostatus disclosure, and

their fears that patients and the general public may be losing trust in nurses as a result of the intersection of nursing practice and criminal prosecutions for serostatus nondisclosure. As a result of these findings, five recommendations were drafted.

Recommendations

- Develop national principles of counselling for HIV/AIDS nursing practice which provide an explanation and a justification for disclosure counselling in addition to clear indications on how to implement disclosure counselling in practice. These principles would inform discussions about policies, practices and standards. *For an example of national principles, please refer to the principles developed by the American Nurses Association.*
- Develop best practice guidelines for disclosure counselling and nursing documentation that take into consideration the specificities of HIV/AIDS nursing practice. These best practices guidelines could

provide guidance to nurses and reinforce existing provincial practice standards. *For an example of best practices guidelines and professional standards, please refer to the Registered Nurses Association of Ontario and the College of Nurses of Ontario.*

- Develop institutional policies on HIV disclosure which include a detailed description of relevant principles, laws, standards, and responsibilities that guide nursing practice (confidentiality, documentation, duty to warn, counselling, and so on). *For an example of an institutional policy on HIV disclosure, please refer to the policy developed by Vancouver Coastal Health entitled “Disclosure of HIV exposure: Policy for VCH staff”.*

- Call for greater mobilisation to address HIV criminalization in the larger realm of political, legal, cultural, and social complexities. This would provide an opportunity for nurses to expose the tensions that exist between law and health care by presenting the impossibilities of nursing practice in the current context. *For an example of advocacy work, please refer to the discussion paper released by the Canadian Nurses Association on harm reduction.*

- Call for greater involvement and advocacy to address HIV criminalization more broadly, to identify new possibilities for collective actions, and to shape how to respond to injustices such as those produced by the application of criminal laws in matters related to HIV nondisclosure. *For an example of advocacy work, please refer to the position statement released by the Canadian Association of Nurses in AIDS Care on HIV criminalization.*

7



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