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978-1-107-09182-5 - Criminalising Contagion: Legal and Ethical Challenges of Disease Transmission and the Criminal Law

Edited by Catherine Stanton and Hannah Quirk

Excerpt

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Disease Transmission and the Criminal Law: A Growing Concern?

HANNAH QUIRK AND CATHERINE STANTON

States have a responsibility to protect their citizens and at times have to take coercive action to isolate or incapacitate those who carry infectious diseases and threaten the health of others. Such measures have included the fourteenth-century Venetian requirement for ships arriving from plague infected ports to sit at anchor for forty days¹ before landing; the forcible medical examination and detention of female sex workers under the Contagious Diseases Act 1864 in England;² and the closure of businesses and the cancellation of Christmas celebrations in Sierra Leone in 2014 in response to the Ebola epidemic.³ Article 5 of the European Convention on Human Rights (the right to liberty and security) provides an exemption for ‘the lawful detention of persons for the prevention of the spreading of infectious diseases...’⁴ There are many methods that states can deploy for dissuading individuals from spreading infection, including providing education, offering encouragement or incentives, and imposing civil regulations.⁵ Until recently, few societies have attached criminal liability to disease transmission.⁶ Whilst public health orders lack the expression

¹ The word ‘quarantine’ is derived from the Italian words *quaranta giorni* meaning ‘forty days’ (E. Tognotti, ‘Lessons from the history of quarantine, from plague to influenza A’, *Emerging Infectious Diseases*, 19: 2 (2013), 254.

² Similar versions were enacted in most of the colonies, see, for example, P. Levine, ‘Venereal disease, prostitution, and the politics of Empire: the case of British India’, *Journal of the History of Sexuality*, 4 (1994), 579.

³ ‘Ebola crisis: Sierra Leone bans Christmas celebrations’. www.bbc.co.uk/news/world-africa-30455248, 12 December 2014.

⁴ Article 5(1)(e) European Convention on Human Rights and Fundamental Freedoms.

⁵ State action is not always necessary. The villagers of Eyam in Derbyshire, England, heroically isolated themselves in 1665–6 to stop the spread of the plague (W. Wood, *The History and Antiquities of Eyam* (London: Thomas Miller, 1842)).

⁶ The Canadian Criminal Code included an offence of knowingly transmitting a venereal disease, but this was repealed in 1985, largely because it had not been used since 1922 (J. Chalmers, ‘Ethics, law, and medicine: the criminalisation of HIV transmission’, *Sexually Transmitted Infections*, 78: 6 (2002), 448–51).

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of censure and imposition of punishment that characterise a criminal conviction, this may be of cold comfort to those who experience such measures as repressive, demeaning, discriminatory or unjust. The powers exercised by public health authorities, such as the use of quarantine or enforced treatment, can be equally or even more draconian than the punishments imposed by the criminal courts, and may be applied without the due process safeguards that apply to trials. Nevertheless, the professed aim of the authorities is to curb the spread of disease – usually only those that are incurable or highly injurious – rather than to punish or to condemn the person spreading the disease. For reasons that are not entirely clear, there has been a shift from the use of public health legislation to that of the criminal law in response to HIV transmission. The lack of clarity in the law in many jurisdictions, and the uncertainty as to how it may develop, makes this fertile ground for scholars and practitioners.

There is no straightforward definition of what behaviours should constitute crimes. The extensive literature around criminalisation discusses the various rationales for criminalisation; a process that has become so chaotic that Ashworth dismisses it as a ‘lost cause’.⁷ There are certain broad characteristics, however. Crime is regarded as having a public quality (the wrong done is deemed harmful to society as a whole, rather than just to the individual ‘victim’) – this is why the state prosecutes criminal cases⁸ – and there is a symbolic or expressive function to its exercise. The classic liberal position of John Stuart Mill is that ‘[t]he only purpose for which power can be rightfully exercised over any member of a civilised community against his will is to prevent harm to others’,⁹ thus the criminal law might appear an appropriate tool to deter or to sanction¹⁰ the transmission of disease. Harm, of itself, is not a sufficient reason to prosecute, however: ‘[t]here are principled reasons not to criminalize all wrongful and blameworthy conduct, even if the practical difficulties of enforcement could be overcome’.¹¹ Culpability is usually essential in establishing criminal liability – not just that an individual caused harm, but that he or she was blameworthy in so doing.¹² It would be unfair to punish those who did

⁷ A. Ashworth, ‘Is criminal law a lost cause’, *Law Quarterly Review*, 116 (2000), 225.

⁸ R. A. Duff, *Answering for Crime* (Oxford: Hart, 2007).

⁹ J. S. Mill, ‘On liberty’, in J. Mill, *On Liberty and Other Essays* (ed. J. Gray) (Oxford: Oxford University Press, 1991), p. 14.

¹⁰ A. von Hirsch, *Censure and Sanctions* (Oxford: Oxford University Press, 1993).

¹¹ D. Husak, ‘The nature and justifiability of non-commensurate offenses’, *Arizona Law Review*, 37 (1995), 151, 155.

¹² A. Honoré, *Responsibility and Fault* (Oxford: Hart, 1998).

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not know that they were ill for example, or did not understand how they might transmit an infection. Yet even if moral culpability for causing harm is present, many of those opposed to the criminalisation of disease transmission argue against adding the stigma of criminalisation to that already faced by the sick.¹³ Many prioritise the protection of public health over the attribution of criminal liability, arguing that a criminalisation strategy is counter-productive as it may discourage engagement with healthcare providers which may increase the risk of disease transmission.¹⁴ Weait argues that 'if we start from a set of *a priori* assumptions about the function(s) of the criminal law in this context, and treat incidents of HIV transmission simply as an opportunity to apply the principles which have traditionally informed the law relating to non-fatal offences against the person, we risk doing more harm than good'.¹⁵ It has also been argued that using the criminal law in this way, putting the onus upon the HIV positive partner, detracts from the public health message of encouraging notions of shared responsibility for 'safer sex'.¹⁶

States have adopted a variety of approaches to criminalisation. Some jurisdictions have enacted HIV-specific statutes; others have applied existing criminal laws (primarily offences against the person acts). The wrong that is being punished varies; it can require the actual transmission of disease, which may be a matter of (bad) luck: as in England; or merely the reckless exposure of another to the disease, regardless of the outcome, as in Canada. There is no consistent rationale as to which types of disease transmission are deemed appropriate for a criminal sanction. HIV and syphilis can both be life threatening if left untreated but, to take three examples from the United States of America, only the transmission of HIV is criminalised in Colorado; Alabama does not differentiate between sexually transmitted diseases; but in Louisiana, HIV exposure is a felony, whereas exposure to other sexually transmitted diseases is a misdemeanor.¹⁷

¹³ R. Jürgens, J. Cohen, E. Cameron, S. Burris, M. Clayton, R. Elliott, R. Pearshouse, A. Gathumbi and D. Cupido, 'Ten reasons to oppose the criminalization of HIV exposure or transmission', *Reproductive Health Matters*, 17: 34 (2009), 163–72, 166.

¹⁴ C. L. Galletly and S. D. Pinkerton, 'Conflicting messages: how criminal HIV disclosure laws undermine public health efforts to control the spread of HIV', *AIDS and Behavior*, 10 (2006), 451–61.

¹⁵ M. Weait, 'Knowledge, autonomy and consent: *R v Konzani*', *Criminal Law Review*, (October 2005), 763–72.

¹⁶ M. Weait, 'Taking the blame: criminal law, social responsibility and the sexual transmission of HIV', *Journal of Social Welfare and Family Law*, 23 (2001), 441–57.

¹⁷ See www.criminaldefenselawyer.com/resources/transmitting-std-criminal-laws-penalties.htm, last accessed 5 July 2015.

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Chlamydia can cause arguably more serious harm than herpes as it can lead to infertility but thus far only HIV and herpes transmission have been prosecuted in England.¹⁸ We are not aware of any prosecutions for disease transmission arising from intravenous drug users sharing infected needles in England and Wales, but fourteen US states have requirements for disclosure between needle sharers.¹⁹ There are immense practical difficulties in proving to a criminal standard that a defendant intentionally or recklessly transmitted a disease to the victim, in particular, establishing causation; just because A discovers that she is HIV positive after having sex with B, does not prove that B is the source. As with other sexual offences, cases involving stereotypical ('innocent') victims and predatory or promiscuous defendants may be more likely to result in convictions. This may be why groups seen as 'Other', such as migrants and sex workers, appear to have been prosecuted disproportionately.²⁰ While the problems and solutions in individual countries may differ, the underlying principles require similar attention.

This edited collection arose from a series of four seminars funded by the Economic and Social Research Council (ESRC)²¹ held between January 2013 and September 2014 which were hosted by the University of Manchester and the University of Southampton (after our project partner David Gurnham moved there).²² We would like to thank the ESRC for its assistance and David for his input in the early stages of the development of this collection. As with so much research at the intersection of medical and criminal law, this project was the brainchild of Professor Margot Brazier and one of the offshoots of the many investigations she has led at the Centre for Social Ethics and Policy at the University of Manchester.²³

¹⁸ *R v Golding* [2014] EWCA Crim 889.

¹⁹ J. S. Lehman, M. H. Carr, A. J. Nichol, A. Ruisanchez, D. W. Knight, A. E. Langford, S. C. Gray and J. H. Mermin, 'Prevalence and public health implications of state laws that criminalize potential HIV exposure in the United States', *AIDS and Behavior*, 18 (2014), 724.

²⁰ H. Worth, C. Patton and D. Goldstein, 'Introduction to special issue: reckless vectors: the infecting "other" in HIV/AIDS law', *Sexuality Research and Social Policy*, 2: 2 (2005), 3–14.

²¹ ES/J021555/1 *Criminalising Contagion: Legal and Ethical Challenges of Disease Transmission and the Criminal Law*.

²² *Criminalising Contagion: Legal and Ethical Challenges of Disease Transmission and the Criminal Law*. Final Report available at www.southampton.ac.uk/icjr/news/2014/11/25_criminalising_contagion_summary.page?

²³ Inter alia, M. Brazier and S. Ost (eds.), *Medicine and Bioethics in the Theatre of the Criminal Process. Bioethics and the Criminal Process* (Cambridge: Cambridge University Press, 2013); A. Alghrani, R. Bennett and S. Ost (eds.), *The Criminal Law and Bioethical Conflict: Walking the Tightrope* (Cambridge: Cambridge University Press, 2012); D. Griffiths and A. Sanders (eds.), *Bioethics, Medicine and the Criminal Law* (Cambridge: Cambridge University Press, 2013).

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We are indebted to her for her intellectual generosity and support. Much of the debate in this area focuses on whether disease transmission should be addressed from a criminal or public health perspective. We are thus delighted, that Margot and Professor Larry Gostin, one of the leading international scholars in public health, have written the foreword for this collection and we would like to thank them both for that.

We sought a range of inter-disciplinary and international perspectives on these issues. Seminar participants included lawyers, ethicists, social scientists, journalists, criminal justice and healthcare practitioners from the United Kingdom, Norway, the United States of America and Canada. We are grateful to all those who presented their work²⁴ and also to those who attended and contributed to the discussions. The chapters in this book by Ceri Evans, Alana Klein, Karl Laird and Aslak Syse are based on papers given at these seminars. A number of additional publications resulted from the seminars and all benefitted from the lively exchange of ideas that occurred there. Each chapter in this book was reviewed by both editors and was sent to an external 'blind' reviewer. Whilst we cannot name the reviewers here, we would like to record our appreciation and that of our contributors for their efforts which have strengthened this collection.

A UK-based seminar series is necessarily constrained in its range of delegates. To counterbalance this, we put out a call for publications as part of a series of three special issues across the *British Medical Journal* publications²⁵ to include the perspectives of some of those who were unable to join the seminars. This widened the debate to include areas such as United Nations' policy and legislation in Africa, which are not covered in this volume.²⁶ Most of the literature in this area focuses on HIV and

²⁴ James Chalmers (University of Glasgow), John Coggon (University of Southampton), Sharon Cowan (University of Edinburgh), John Dilworth (CPS), Ceri Evans (Society of Sexual Health Advisers), Steven Evans (36 Bedford Row Chambers), David Fenton (BBC), John G. Francis (University of Utah), Peter Greenhouse (BASHH), David Gurnham (University of Southampton), Imogen Jones (University of Birmingham) Alana Klein (McGill University), Karl Laird (University of Oxford), Maggie O'Neill (Durham University), Matthew Phillips (Manchester Centre for Sexual Health), Leslie Picking Francis (University of Utah), James Slater (University of Buckingham), Lucy Stackpool-Moore (SOAS), Aslak Syse (University of Oslo) and Matthew Wait (Birkbeck School of Law) (affiliations stated are those which applied at the time of the seminars)

²⁵ *Sexually Transmitted Infections*, 89:4 (2013), 274–94 (edited by David Gurnham); *Medical Humanities*, 39:2 (2013), 75–84 (edited by Hannah Quirk); *Journal of Medical Ethics*, 40:12 (2014), 792–801 (edited by Catherine Stanton). We were sorry to hear of the death of Sue Eckstein, the editor of *Medical Humanities*, just before the special issue was printed.

²⁶ D. Grace, 'Legislative epidemics: the role of model law in the transnational trend to criminalise HIV transmission', *Medical Humanities*, 39 (2013), 77–84; P. O'Byrne, A. Bryan and

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other sexually transmitted infections. We found it difficult to move as far beyond this as we had initially intended, but most of the arguments and ideas raised can be extrapolated to other diseases.

We quickly found this topic is like no other area of criminal law. It was striking throughout the seminar series how differently most academics and practitioners regarded the reckless transmission of HIV to other crimes; as Mawhinney observes, '[a] culture of sympathy comes through much of the research critical of criminalisation of HIV transmission.'²⁷ In recent years, criminal justice scholarship and policy has taken a much greater interest in the victims of crime.²⁸ In the United States and the United Kingdom, funding has been increased for victim support groups, which have been given greater involvement in policymaking. Evidential changes have been made, such as the use of victim impact statements, in order to 'rebalance' a criminal justice system which has been criticised for overly favouring the rights of defendants.²⁹ In the area of disease transmission, however, it appears that the experience of the victims is often underplayed – it was noteworthy throughout the seminars how often the effects of HIV and a lifetime on medication were minimised, and how the boundaries between offender and victim were blurred, as the 'offender' was, of course, also victimised when infected. One seminar attendee recalled a newly diagnosed 'angry young man' wanting the person who had infected him to be prosecuted, and how instead he was counselled to address his responsibility for exposing himself to infection. Such 'victim blaming' is increasingly out of favour in criminal justice policy, particularly in relation to sexual offences. Unlike other crimes, which are often justified as protecting the freedoms of others, autonomy was discussed primarily in terms of those with HIV – their right to have sex and not to have to disclose their status – with

M. Roy, 'HIV criminal prosecutions and public health: an examination of the empirical research', *Medical Humanities*, 39 (2013), 85–90. On the use of model law see also: D. Grace, 'Criminalizing HIV transmission using model law: troubling best practice standardizations in the global HIV/AIDS response', *Critical Public Health*, 25: 4 (2015), 441–54.

²⁷ G. R. Mawhinney, 'To be ill or to kill: the criminality of contagion', *Journal of Criminal Law*, 77:3 (2013), 202, 203.

²⁸ United Nations A/RES/40/34, 29 November 1985, Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power; Council of Europe Framework Decision of 15 March 2001 on the standing of victims in criminal proceedings (2001/220/JHA); Directive 2012/29/EU; J. Doak, *Victims' Rights, Human Rights and Criminal Justice: Reconciling the Role of Third Parties* (Oxford: Hart Publishing, 2008); I. Vanfraechem, A. Pemberton and F. Mukwiza Ndahinda (eds.), *Justice for Victims: Perspectives on Rights, Transition and Reconciliation* (Abingdon: Routledge, 2014).

²⁹ J. D. Jackson, 'Justice for all: putting victims at the heart of criminal justice?', *Journal of Law and Society*, 30: 2 (2003), 309.

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much less consideration given to the right of ‘victims’ to (refuse) consent to exposure to any risk, however slight. The majority view was clearly that criminalising disease transmission was unfair, counter-productive in public health terms, and potentially discriminatory.

This collection begins with a provocative suggestion by Matthew Weait that HIV should not be thought of as a ‘harm’ for the purposes of the criminal law. Weait argues that the debate has become frozen between two conflicting perspectives – those who object to criminalisation by focusing on its negative effects in terms of stigmatisation and public health campaigns, and those who adopt the orthodox approach that HIV is a criminally significant harm. While acknowledging ‘the seriously adverse physical, psychological and social impact that HIV may have on people’,³⁰ he offers a bold attempt to reframe the debate by reassessing what is meant by harm. He explains how the conceptualisation of the body in criminal law has developed from a porous entity at the whim of the gods in medieval times, to a molar single entity today. Weait argues that ‘the bodily integrity assumed by the criminal law is illusory’ and that by deconstructing notions of ‘the body’ and taking a ‘post-human’ approach, the idea of harm can be reassessed. He argues that ‘[t]he bodies of people living with HIV are merely composite in a different way from those not living with HIV... People living with HIV are normal, in this sense, in the same way that people living without HIV are normal.’³¹ Weait contends that the decision to criminalise an activity is a political choice, and that any argument for or against criminalising the transmission of disease, must acknowledge this and interrogate the assumptions that underlie it.

Such definitional issues are important, as how a subject is conceptualised sets the parameters for debate and the possibilities for action. Michael Hanne’s chapter examines the use of metaphor in relation to illness and crime. He explores the associations between the two concepts, the overlaps and shifting boundaries, over time and between cultures, and the ways in which societies seek to correct or to cure both problems. Using a range of sociological and historical examples, he explains how illness and criminality are regarded by most societies as a form of social deviance – the former generally being regarded more sympathetically, but sometimes as a punishment for the latter (see, for example, the startling campaigns of the Westboro Baptist Church in the United States that views AIDS and war as

³⁰ Weait, Chapter 1, this volume, at 19.

³¹ *Ibid.*, at 32.

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God's punishment for society permitting homosexuality³²). As Weait does, he argues that there are political factors that contribute to how notions of blame, culpability and criminal justice policies are constructed, such as policies that criminalise the transmission of HIV, but not the businesses that damage life expectancy through pollution or fast food. In all these discussions, Hanne argues that it is important to understand the role of the language used and how this in turn can influence the debate. He examines the widespread use of both 'disease as crime' and 'crime as disease' metaphors, and the danger that this may lead to the collapse of the boundary between the two concepts. There are often overlaps between the populations most susceptible to disease and those with the highest crime rates. He urges therefore that, while the use of metaphor should not be abandoned, there is a need to be critical about its usage.

Words are enormously important, and how a disease is named is also significant. When clusters of Kaposi's sarcoma and pneumocystis pneumonia were noted among gay males in Southern California and New York City in the early 1980s, it was proposed to call the condition that became known as HIV-AIDS, 'Gay-Related Immune Deficiency' (GRID).³³ In the British press – broadsheet as well as tabloid – the disease was dubbed a 'gay plague'.³⁴ This labelling of the disease appeared to affect public responses to it – from, British Prime Minister, Margaret Thatcher's reluctance to run a public information campaign that might risk offending public sensibilities,³⁵ to the outright discrimination that many HIV positive (and gay people generally) suffered as a result. A leader in *The Times* newspaper opined that 'the infection's origins and means of propagation excites repugnance, moral and physical, at promiscuous male homosexuality'.³⁶ The World Health Organisation recently called upon scientists, national authorities and the media to avoiding giving diseases names associated with places or species (such as Spanish or bird flu) or groups (such as Legionnaires' Disease). It reasoned that certain disease names may 'provoke a backlash against members of particular religious or ethnic communities, create unjustified barriers to travel, commerce and trade,

³² www.godhatesfags.com.

³³ www.cdc.gov/mmwr/preview/mmwrhtml/00001114.htm.

³⁴ 'Spread of the "Gay Plague"' *Mail on Sunday* 1 May 1983; '"Gay Plague" may lead to blood ban on homosexuals' *Daily Telegraph*, 2 May 1983; 'Alert over "Gay Plague"' *Daily Mirror* 2 May 1983; '"Watchdogs in "Gay Plague" probe' *The Sun* 2 May 1983.

³⁵ S. Garfield 'Saying the Unsayable' *The Independent*, 11 November 1995.

³⁶ *The Times*, 21 November 1984. Newspaper details reported in A. McSmith, *No Such Thing as Society* (London: Constable, 2011).

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and trigger needless slaughtering of animals. This can have serious consequences for peoples' lives and livelihoods.³⁷ As Kerri Inglis explains in her chapter, leprosy was renamed Hansen's Disease in an effort to reduce the associated stigma but, as she notes, the naming is of significance, not just to the wider community, but to those with the condition as 'naming or labelling of course brings with it implications of identity'.³⁸

We soon realised that it was almost impossible to separate the debate around criminalising disease transmission from these notions of identity and the experiences of those who have lived with and/or campaigned against the stigma faced by those with HIV. To newcomers to the debate, it seems perfectly possible not to be homophobic or racist, yet to advocate criminalisation of HIV transmission, but for many of those with longer or personal experience in this area, the terms of the debate appear to have been set by its history. Inglis's chapter offers a fascinating historical perspective on this issue by examining the use of the law to prevent the spread of Leprosy in Hawai'i between the mid-nineteenth and twentieth centuries. She draws upon moving personal testimony and contemporaneous accounts to illustrate how a policy with benign original intentions came to be experienced as oppressive, humiliating and racist. It was imposed by a colonial authority on primarily indigenous patients. In the face of an incurable epidemic of unknown origin, the authorities set up a quarantine regime: 'Geographically and culturally, this was to be a land "set apart"'.³⁹ The language used became increasingly punitive – patients became prisoners and the way in which the inmates were treated and regarded carried as much stigma as those subject to the criminal law. Patients were subject to compulsory sterilisation, degrading physical examinations and were separated from their families. Medical advancements ended the need for these 'geographies of exclusion',⁴⁰ but former patients continue to work to address the additional stigma imposed on them by the law.

Several of our contributors emphasised this importance of examining the effects of the criminal law in practice. Ceri Evans, a sexual health adviser in London notes in her chapter how, just as lawyers and legislators struggle keeping up to date with medical advances, healthcare professionals now have to understand and communicate accurately to their patients the current state of a complex, changing area of law. Although

³⁷ www.who.int/mediacentre/news/notes/2015/naming-new-diseases/en/

³⁸ Inglis, Chapter 3, this volume, at 58.

³⁹ *Ibid.*, at 56.

⁴⁰ *Ibid.*

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transmission of herpes and HIV would be charged under the same law by prosecutors, the populations affected by, and the clinical differences between, the two viruses require very different responses from healthcare practitioners. Evans details the significant practical challenges she and her colleagues have to navigate with the newly diagnosed, including judging when to mention potential criminal liability. Staff may ‘sigh with relief once the potentially tricky area of criminalisation has been navigated for the first time’,⁴¹ but their responsibilities do not end there. The increased life expectancy of those complying with their treatment means that their situations and relationship statuses are likely to change. Whilst ‘being ill does not absolve a person of her normal legal and moral responsibilities to other people’,⁴² following the shock of diagnosis, people may be unable to understand, retain or process such information.⁴³ Healthcare professionals may be called upon to testify in criminal proceedings – for the prosecution or defence – about the patient’s understanding of any advice given.⁴⁴ A sense of divided loyalties between their patients and members of the public⁴⁵ is not unique to sexual healthcare workers, but Evans argues that the imposition on them is particularly difficult. She explains that the history of HIV and the stigma these patients continue to face has forged a distinct professional sense of self, in particular as protectors of their patients. There is a special relationship between healthcare professionals and their clients, and ‘[i]t may then feel like a betrayal for those patients and staff to acknowledge that issues of criminalisation, safer sex and partner notification may need to be discussed.’⁴⁶

Globally, there has been a range of approaches to the use of the criminal law in relation to HIV transmission. The first prosecution in Scotland for the sexual transmission of disease for over a century occurred in February 2001, in relation to transmitting HIV.⁴⁷ In England and Wales,

⁴¹ Evans, Chapter 4, this volume, at 87.

⁴² M. Brazier, ‘Do no harm – do patients have responsibilities too?’ *The Cambridge Law Journal* (2006), 397 at 406.

⁴³ M. D. Phillips and G. Schembri, ‘Narratives of HIV: measuring understanding of HIV and the law in HIV positive patients’, *Journal of Family Planning and Reproductive Health Care*, online, 14 January 2015, doi:10.1136/jfprhc-2013-100789.

⁴⁴ For a recent study examining the impact of the criminal law on how public health nurses in Ontario record their consultations with HIV positive clients see: C. Sanders, ‘“Examining public health nurses” documentary practices: the impact of criminalizing HIV non-disclosure on inscription styles’, *Critical Public Health*, 25:4 (2015), 398–409.

⁴⁵ See C. Dodds et al., *Keeping Confidence: Responsibility and Public Health* (Sigma Research, 2013).

⁴⁶ Evans, Chapter 4, this volume, at 92.

⁴⁷ Chalmers, ‘Ethics law and medicine’.