

Discussing the Limits of Confidentiality: The Impact of Criminalizing HIV Nondisclosure on Public Health Nurses' Counseling Practices

Chris Sanders*, Center for AIDS Intervention Research, Medical College of Wisconsin

*Corresponding author: Chris Sanders, Center for AIDS Intervention Research, Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin, 2071 North Summit Ave, Milwaukee, WI 53202, USA. Tel.: +1 414 955 7715; Email: tsanders@mcw.edu

In Canada, there have been a growing number of criminal HIV nondisclosure cases where public health records have been subpoenaed to aid in police investigations and/or to be presented in court as evidence against HIV-positive persons. This has led some to suggest that nurses provide explicit warnings about the limits of confidentiality in relation to crimes related to HIV nondisclosure, while others maintain that a robust account of the limits of confidentiality will undermine the nurse–client relationship and the public health goals of reducing HIV/sexually transmitted infection transmission. This article engages with this issue by exploring whether and how public health nurses endeavor to control information about the limits of confidentiality at the outset of HIV posttest counseling. The data indicate variation in practices, as nurses pragmatically balance ethical and professional concerns; although some nurses intentionally withhold information about the risk of subpoena, others report talking to clients about confidentiality in ways that focus on the risk of harm associated with criminalization. The discussion argues that practice variation also illuminates medico-legal relations between health care and the criminal justice system. Data are drawn from qualitative interviews with 30 nurses working at four public health units in Ontario.

Introduction

In health-care settings, it is common for clients to entrust sensitive personal information to providers, which is then deemed 'confidential' or protected information (Wasserstrom, 1986). Protecting confidentiality, in turn, refers to a series of actions whereby providers take steps to ensure that a client's health and other personal information are not shared beyond the clinical encounter. Common breaches of confidentiality by providers include accidentally or intentionally discussing their clients with family, friends or colleagues, or, breaches can occur through unauthorized access to patient records (e.g., unattended or unlocked filing cabinet, unsecured computers or email). Breaches of confidentiality may also be necessitated by professional obligation, such as when a provider makes a conscious decision to violate confidentiality because a client is deemed dangerous to him- or herself or another.

Similarly, in the context of public health practice the principle of confidentiality has recently come into focus with regard to communicating health information and establishing provider–client relationships (Haider and Everett, 2005). In the case of HIV posttest counseling, for example, Ontario public health nurses are required to counsel all newly diagnosed HIV-positive clients about living with HIV, seeking medical care, reducing risk behaviors most likely to transmit HIV and of their criminal law obligation to disclose their serostatus to sex partners. In addition, public health nurses elicit contact information for sex partners who must be notified of possible exposure to the virus. Protecting confidentiality in these instances entails preventing unauthorized access to the individual health records that contain information about a client's HIV-positive serostatus and details about his or her risk behaviors and sex partners.¹ At the start of HIV counseling, nurses advise clients that the only circumstances under which confidentiality is

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broken are when a nurse fears that a client intends to physically harm him- or herself or someone else. Until recently, this construction of harm has been the only foreseeable way that the criminal justice system could encroach upon confidentiality.

Circumstances changed, however, after the Supreme Court of Canada held that HIV-positive persons have a legal obligation to disclose their serostatus to sex partners prior to engaging in behavior that poses a significant risk of serious bodily harm (e.g., HIV transmission) (*R v. Cuerrier*, 1998). Since the ruling, there have been a growing number of criminal HIV nondisclosure cases where public health records have been subpoenaed to aid in police investigations and/or to be presented in court as evidence against HIV-positive clients (Symington, 2009).² Although public health nurses are not in the habit of contacting police with concerns about clients, the possibility of subpoenaing public health records means that the criminal justice system nonetheless can gain access to a wealth of information that can be used against a client in the event of an arrest. In short, criminalizing HIV nondisclosure has opened up a wider space for the criminal law to intrude upon the confidentiality of the counseling session.

For many, this is a concerning development given that a conviction for aggravated sexual assault stemming from HIV nondisclosure can result in receiving sexual offender status or imprisonment. This development has led some to recommend that nurses provide explicit warnings about the limits of confidentiality in the event that a client is charged with sexual assault or aggravated sexual assault for failing to disclose HIV status (O'Byrne, 2011). An opposing perspective, however, is that a robust account of the limits of confidentiality is likely to undermine the nurse-client relationship and the goals of public health counseling, which include identifying and notifying sexual partners of exposure to HIV in order to seek testing and, if necessary, treatment. This conflict presents an opportunity to explore and reflect upon how clients are currently advised about the limits of confidentiality and whether this standard of practice should be modified in response to the potential risk of a subpoena.

This article engages with this dilemma by exploring two research questions: what, if anything, do public health nurses explain to HIV-positive clients about the limits of confidentiality brought about by criminal HIV exposure laws? What reasons guide nurses' decisions about whether and how to advise clients about this particular threat posed by the criminal law? The main finding is that variation in how nurses attempt to control information about the limits of confidentiality reflects a

pragmatic response to criminalization cases as being part of the ethical continuum of balancing duty to warn and protect. This finding also illuminates the influence of medico-legal relations on public health HIV posttest counseling practice. The discussion draws on insights from the 'medico-legal borderland', a sociological framework for critically analyzing relationships and sites of intersection between health practice and the criminal justice system (Timmermans and Gabe, 2003). This perspective shines light on how external institutions, namely, the criminal justice system, can influence the counseling practices of public health nurses. By so doing, the critique remains focused on structural influences rather than the nurses whose counseling work has been complicated by this ethical dilemma.

Literature and Methods

To avoid confusion about what these nurses are doing in the context of HIV posttest counseling, it is useful to distinguish between obtaining informed consent and advising about the limits of confidentiality. Obtaining informed consent refers to a communication between the provider and patient, which results in a patient agreeing, of his or her own volition, to undergo a particular medical treatment or procedure. This communication must include a description of the procedure or treatment, any risks and benefits, the odds of success and alternative procedures or treatments. Typically informed consent occurs in a clinical or hospital setting, and includes a signed document that is considered legally binding.

In the present setting, however, public health nurses are not obtaining informed consent based on traditional volunteerism, as HIV posttest counseling is, for all intents and purposes, mandatory with new HIV diagnoses as well as for HIV-positive clients who subsequently test positive for sexually transmitted infection (STI) co-infections. Instead, what is at issue in this article is how forthcoming nurses are about the limits of confidentiality at the outset of counseling and why, given their awareness of the growing risk of a subpoena being issued in criminal HIV nondisclosure cases.

In case law, confidentiality refers to a legal and ethical responsibility to protect a client's privacy within the confines of a legal duty to warn another of the risk of harm (e.g., Tarasoff, 1976). Textbooks frequently present this issue through examples where licensed mental health professionals and social workers are compelled to break confidentiality when a client presents a foreseeable harm to him- or herself or an identifiable other. In the

case of HIV, it has been applied to situations where a clinician learns that an HIV-positive client has not disclosed his or her HIV status to a sex partner, or if he or she attempts to intentionally infect others with the virus (Chenneville, 2007). In order to preserve the integrity of the therapeutic relationship, clinicians are typically advised to discuss the boundaries of confidentiality with a client so that he or she may decide what to share in the clinical setting. How closely public health nurses follow this advice is discussed in the findings.

Empirical studies on this issue are situated in two camps, with the first being applied research methodology and the second being broader bioethics debates. The first of these takes the form of methodological discussions of steps taken to protect the confidentiality of research participants while maximizing the benefit of research. For example, Nattinger *et al.* (2010) discuss the use of confidential information from patients' billing records to recruit eligible female participants for a breast cancer study. Sherman and Fetters (2007) describe a technique for masking the identities of women while studying health-care facilities that provide abortion services. Both cases deal with precautionary actions taken in different situations; whereas the first deals with researchers protecting confidentiality in the context of technological shifts, the second case focuses on protecting confidentiality against the possibility of humiliation.

The second literature base invokes ongoing bioethics debates about protecting the medical confidentiality of individuals in light of new and evolving threats to the general population. For example, Wynia (2007) discusses how the appropriation of military detainees' health records in the service of interrogations may have contributed to suicide attempts. Wynia points out that while breaching confidentiality is frequently allowed when there is a credible threat of harm to an identifiable third party, in this case decisions were predicated on a potential threat to the broader public.

Others studies have brought the reality of information seizure by the criminal justice system to the forefront of debate. For example, a sociologist studying assisted suicide at the time that a 'right to die' case went before the Supreme Court of Canada was asked to identify interviewees who may have witnessed an assisted suicide. The researcher was threatened with contempt of court and imprisonment for refusing to divulge the information (Lowman and Palys, 2000). In response to such cases, Picou's (1996) summary analysis of several case studies concludes with practical recommendations for protecting data and the identity of research participants from the eventuality of a subpoena.

In short, discussion about the limits of confidentiality tends to be framed in terms of the duty warn and the duty to protect. Shifts in counseling practice often result from new and evolving concerns about technology, law and risk to the general public. When clinicians are obliged to break confidentiality is a frequent topic of debate. Although clinicians are typically advised to describe the limits of confidentiality in order to preserve the therapeutic relationship, this article examines what this discussion entails when describing the limits of confidentiality threatens the provider–client relationship. For example, does the potential for a subpoena take precedence over concerns about counseling rapport or pursuing public health disease prevention goals? The cases reveal variation in practices, with some nurses volunteering more information about the risk of subpoena while others say less or nothing at all. Some nurses share this information only when clients ask, while others feel that addressing the risk of a subpoena is needlessly excessive in the broader scheme of important information covered during posttest counseling. The final discussion revisits and closely reflects on these rationales for the benefit of future counseling practice considerations.

Interview data are excerpted from a purposive sample of 30 nurses from four public health departments in Ontario, Canada. Nurses were selected based on having experience as HIV case managers. All nurses reported that posttest HIV counseling was a regular part of their professional duties. Tenure of experience varied from 2 years to more than 20 years on the job. Nurses were contacted by phone or email, provided a synopsis of the research and asked to participate in a confidential interview. All signed an informed consent form. The study was approved by the university Office of Research Ethics; additionally, the research protocol (including interview guide and informed consent form) was approved by STI department heads and the institutional ethics review boards of participating public health agencies.

Interviews were semi-structured and consistent with DeVault and McCoy's (2002) Institutional Ethnography approach; nurses were asked to walk the interviewer through the counseling process including common examples and the use of standard documents and forms. Participants were asked whether they had knowledge of client records from their health unit being subpoenaed, whether they ever received a summons to testify about a client in relation to a nondisclosure case, whether they believe that they should advise clients about the risk of a subpoena and, why and to describe whether and how they advise clients about this concern. Participants at all four sites reported that client health records had been

subpoenaed in relation to a criminal nondisclosure case. Roughly one-third described having received a summons to testify in court or at a pretrial hearing about a client. Although the consensus among nurses was that both events were still relatively uncommon, all agreed that the frequency appeared to be increasing.

Interviews were recorded and transcribed. Analysis was guided by constructivist grounded theory (Charmaz, 2006); transcripts were reviewed several times to identify relevant ethics concepts and key organizational themes along with accompanying examples.

How Public Health Nurses Discuss the Limits of Confidentiality

Some Nurses ‘Do More’ While Others ‘Do Less’

Public health nurses have different styles of managing what they share about the limits of confidentiality in light of their concerns about maintaining rapport with clients; to borrow from the words of one nurse, some might be said to ‘do more’ while others ‘do less’. In either situation, nurses describe what they say at the outset of counseling as an effort to meet their broad ethical obligation but not in a manner that damages their relationship with clients. In addition to raising a series of ethical questions, the variation in nurses’ reasoning and practices offers a clearer understanding of how they respond to the indirect influence of the criminalization of HIV nondisclosure on their counseling work.

To be clear, some of the nurses report being completely forthcoming at the outset of counseling that among the limitations of confidentiality is the ‘unlikely but potential risk that a health record could be subpoenaed’ (PHN 22). Among those interviewed, however, this practice was uncommon for a number of reasons. In particular, nurses’ accounts suggest that the details included in their cautionary statements about the limits of confidentiality can influence whether trust is lost or gained at the outset of counseling. Two nurses, for example, caution that leading off with warnings about the risk of subpoena threatens counseling rapport and risks a loss of trust needed to discuss risk behavior and elicit contact information for sex partners. As a result, each nurse employs a strategy of avoiding or maneuvering around certain details about the risk of a subpoena. One nurse relates to it in terms of preserving the counseling dynamic:

It’s tricky. Some nurses feel like they must say more and some say less. I’m a nurse, so I don’t

go into detail about that [subpoena] stuff because my goal is to counsel the client about maintaining health and trying to limit future transmissions. If I’m putting them off with warnings about the criminal law and subpoenas, they’re not going to be open and talk to me about their actual hardships. If we can’t talk about those things, then I’m totally ineffective as a nurse. So in my experience you say enough to meet the guidelines. (PHN 11)

Another nurse is also sparing of details about criminal law and the risk of a subpoena in the interest of preserving rapport, though to a strategic end in terms of successfully eliciting contact information for sexual partners:

I do go through confidentiality, but I generally don’t go into the full details. I don’t say, ‘If a court case ever came up, my records could be subpoenaed’. That’ll only shut them down to what I’m trying to tell them about protecting others from transmission and discouraging them from telling me about their partners and risk behavior. How is that going to help along [HIV/STI] prevention? It’s not. So I keep it simple and non-threatening for the sake of the session and what’s gotta get done. (PHN 8)

Both quotes reflect an effort to preserve the therapeutic relationship. Each nurse is to some extent reticent about providing detailed information about the risk of subpoena because of the perceived impact it will have on rapport, trust and ultimately the disease prevention goals of the counseling session. While in the former quote, the nurse emphasizes the goal of tending to the individual client’s health, the nurse in the latter quote is thinking primarily about the goal of preventing onward transmission through harm reduction and by obtaining partner information for contact tracing. In both instances, the nurses feel full disclosure of the limits of confidentiality does not function to preserve the therapeutic relationship, but rather jeopardizes it.

Information Available upon Request

Another approach embraced by nurses is to discuss the limits of confidentiality upon request, an approach that assumes clients know to ask such information in the first place. One nurse, for example, reports a complete willingness to explain the risk of a ‘production order’ (or a subpoena), though the nurse does not proactively broach the topic.

I only go into it if a client asks if we’ve ever received a subpoena, then I have no problem saying that we have. ‘It’s rare, but we have’ is

what I say. And if they ask what happens, then I'm very up front in explaining: If an officer shows up and says, 'Give me this chart,' we don't give it to the officer. We send them away until they have a subpoena. If they come back with one, then that goes through our legal counsel, we'll redact parts of the chart, and then we hand over that version.' So, I explain that if they ask. Otherwise I usually don't see the point in alarming the client because, like I said, it's rare. (PHN 13)

As with the previous examples, this nurse cites concerns about establishing and maintaining rapport. Also, the nurse reasons that because subpoenas are rare there is little point in scaring clients. In this example, the onus is on the client to probe with specific questions about the limits of confidentiality, and the questions need to be rather specific. It is not sufficient that a client simply ask about the limits of confidentiality in order to be told about the potential for a subpoena, but must ask under what circumstances the police can seize his or her case management file.

Further to this point, interviewees were asked whether they had approached supervisors with questions about whether to provide a robust account of the limitations of confidentiality and the risk of a subpoena. According to one nurse:

This was discussed and we concluded that clients have a general awareness of medical protocol and know that sessions are held in confidence, and that only under extreme circumstances of physical harm do healthcare providers violate confidentiality. Given the current litigious climate of criminalization, many of us felt that clients possess awareness that records can be subpoenaed by the criminal justice system. (PHN 11)

The presumption that clients are aware of the current litigious climate brought about by criminalizing HIV nondisclosure, however, may not be supported by research showing that many people are unaware of HIV exposure laws where they live (Galletly *et al.*, 2012). In this case, nurses and their supervisors may be overestimating client knowledge about the impact of these laws and the limitations of confidentiality that result.

Limiting 'Excessive' Detail

One final approach relates to how nurses curtail information about the limits of confidentiality based upon what they consider to be information excess. For instance, various nurses who refrain from discussing the risk of a subpoena with clients dismissed this as

'excessive' or 'too much information' for clients to grapple with during posttest counseling. One nurse, for example, gives the impression that excessive information resembles an overly bureaucratic atmosphere that complicates counseling. She expresses the idea that a robust discussion of confidentiality is unreasonable within the confines of what posttest counseling is intended to accomplish:

I think it's gone too far. If you go strictly by the policy, we should say: 'There's a Health Promotion and Protection Act, and I will keep everything confidential unless A, B, C happens'... now of course it's getting more detailed because of criminalization. It's not realistic to go through every single detail of what is and isn't protected. We only have so much time. So I try to squeeze it into a small 'everything's confidential' unless I think you're gonna hurt anyone. And no, I do not usually spell out that: 'If someone charges you, they're going to subpoena our records, and you and our record are going to end up in court, and this won't be confidential'. (PHN 10)

In this quote, there is a sense from this nurse that providing a robust account of the risks associated with criminalization as part of the limits of confidentiality is both unreasonable with respect to time constraints and burdensome given everything else that must be addressed during counseling. To be clear, this nurse was not referring to concerns about jeopardizing counseling rapport, but rather the idea that there is more important information to discuss such as health promotion and disease prevention.

Granted, the public health literature on client-provider interaction does caution against 'information overload', as there are limits to the amount of information clients understand and retain in a single counseling encounter. In the case of family planning, for example, Murphy and Gryboski (2005: 204) note that clients can feel overwhelmed by a detailed recitation of every contraception method and family planning program, rather than focusing on methods that are best suited to the needs and values of the particular client. Some might reason that this argument similarly applies to focusing on prevention counseling and not 'overloading' with other details. However, this advice more accurately refers to minutia or detail that either waters down major concepts or is irrelevant to client needs. Advising clients about the limits of confidentiality arguably is unlikely to constitute time-consuming or burdensome minutia in the broader scheme of the posttest counseling session.

Discussion and Implications

This research has been inspired by recent cases of public health records being subpoenaed for use against clients in investigations and trials related to the criminalization of HIV nondisclosure (Symington, 2009). The findings illustrate ways that some public health nurses manage information about the limits of confidentiality at the outset of HIV posttest counseling. Whereas traditional breaches of medical confidentiality might result in minor embarrassment or even public humiliation, having one's health record subpoenaed for use in criminal court can result in imprisonment. Interest in exploring this topic arises out of concerns about whether nurses should alert clients to this possibility given that there has been a rapid growth in the number of HIV criminal exposure laws worldwide (Burris and Cameron, 2008) and, in Canada in particular, there has been an alarming increase in arrests and prosecutions related to HIV nondisclosure (Mykhalovskiy and Betteridge, 2012). The findings also explore how practical concerns about public health disease prevention goals inform if and how nurses share, withhold or manage details about the limits of confidentiality with respect to HIV criminalization. In closing, it is worth revisiting the underlying rationales given by nurses to offer counter perspectives that may influence future public health nursing practice or criticisms.

In some instances, nurses withhold information about the risk of a subpoena, while in other instances nurses report being willing to talk to inquisitive clients about the limits of confidentiality in ways that focus on the risk of harm with respect to criminalization. Among this sample of nurses, however, 'saying less' about the limitations of confidentiality more often than not means limiting discussion to the traditional caveats regarding harm to self or others. Few of those interviewed are willing to 'say more' by explaining to clients that information could be used against the client in the event of a subpoena. These nurses cite practical concerns, such as discouraging open dialogue and the importance of collecting partner data, for their decision not to discuss the risk of a subpoena. While concerns about maintaining counseling rapport cannot be discounted, it is also important to recognize that public health professionals can risk losing rapport with the broader community of people living with HIV/AIDS if public health practices are seen to be deceptive by virtue of withholding information from clients, particularly those who may be especially vulnerable to the criminal law.

Some nurses noted that they explain the subpoena risk upon client request because they feel there is already adequate public knowledge of HIV criminalization. Research indicates, however, that only about half of respondents are familiar with the criminal HIV exposure laws in their areas (e.g., Galletly *et al.*, 2012). Interestingly, this reasoning also constructs an image of the counseling dynamic as a legal-rational interaction. Just as Adam *et al.* (2008) critique *Cuerrier* as relying on a 'contractual notion of sexual behavior' that treats consensual sex as a negotiated reason-based interaction, this counseling approach similarly relies on clients to arrive prepared with questions about what statements can later harm them in a legal context. The expectation of a rational and informed mindset perhaps does not adequately acknowledge that some recently diagnosed HIV-positive clients present for counseling feeling distraught and unfocused as opposed to rational and level-headed. For the nurses who describe this approach, it may be worth revisiting this reasoning in the event that it affects their future counseling practices.

Related to this, some of the nurses explained that the 'rarity' of a subpoena (or an arrest) was reason enough to refrain from a robust discussion about the limits of confidentiality. Indeed, all of the nurses who were interviewed spoke of how 'uncommon' or 'rare' it is for people who are HIV-positive to be charged in relation to HIV nondisclosure. While it is true that relatively speaking these cases are uncommon, it is also true that suicide and other forms of physical harm that trigger breaking confidentiality are uncommon. Yet, these caveats are nonetheless part of the counseling protocol regarding the limits of confidentiality. Again, for some nurses it may be beneficial to reconsider whether the rarity of arrest or of a subpoena is adequate grounds to avoid discussing this issue given that other uncommon risks of harm are addressed as exceptions to confidentiality protections.

Still other nurses reasoned that including the risk of subpoena as one of the limits of confidentiality constituted excessive detail, and that clients are likely to already have awareness of this fact. One could counter, however, that nurses have an obligation to discuss this risk because many people assume that health-care providers always act in the interests of clients. Research by Corrigan (2003: 780), for example, found that popular health-care norms, such as the do-no-harm principle, strongly influence patients' willingness to participate in clinical research trials. In other words, in the absence of evidence to the contrary, participants accepted the benevolence of medical practice and agreed to participate regardless of a clear understanding of risks. If patients in

health-care studies assume benevolent practice based on cultural norms, then there is reason to presume that some clients of public health will share similar assumptions. This means that unless public health nurses take the initiative to provide detailed accounts of the limits of confidentiality including the risk of a subpoena, some clients may have no reason to suspect such risk exists.

In closing, all of the nurses felt that an increasing emphasis on issues tied to HIV criminalization jeopardizes the tasks of risk reduction counseling and eliciting sex partner information. Descriptive phrases like ‘alarming clients’ and ‘shutting down’ in reference to counseling interaction are telling indicators that, from the nurses’ perspectives at least, discussing matters related to criminalization has a disquieting effect on some clients. Similarly, Mykhalovskiy (2011: 671–2) finds that HIV health-care providers worry that emphasis on criminalizing HIV nondisclosure hinders efforts to work with HIV-positive by discouraging them from openly discussing their sexual activities and disclosure practices. The findings presented above add another layer by demonstrating that some nurses respond to such concerns by withholding information about the limitations of confidentiality or relying on clients’ knowledge and initiative in being able to ask about the specific risk of a subpoena. Clearly, concerns about the impact of criminalizing HIV nondisclosure can influence counseling practices in subtle, unexpected ways that deserve ongoing analytic attention.

Sociologically speaking, what is interesting about the findings and the discussion points noted above is that whether and how nurses manage information about the limits of confidentiality has surfaced as an emerging medico-legal tension in public health counseling practice. According to Timmermans and Gabe (2003), the ‘medico-legal borderland’ is a critical analytic tool for grasping how the criminal justice system inadvertently influences provider practices and reasoning in health-care settings. Of course, providing some cautionary statement about the limits of confidentiality has always been standard public health counseling practice. The robustness of that message, particularly with respect to the risk of a subpoena, is an issue that some nurses now report having to contend with during counseling. In this instance of medico-legal relations, the criminal law can be viewed as a structural force that obscurely impacts important micro-level interaction between nurses and clients during HIV posttest counseling. This outcome, of course, is not the fault of the nurses, as they are simply the face of public health disease prevention and, according to these data, are attempting to

pragmatically manage the situation within the context of their counseling duties.

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Notes

1. In addition to guarding against embarrassment, maintaining confidentiality is understood to help foster counseling rapport insofar as clients will be more willing to provide sensitive information or ask uncomfortable questions when there is assurance that what they share will be held in strict confidence (McGough and Handsfield, 2007; Semaan and Leinhos, 2007).
2. A police investigator, for example, may look to information contained in the nurse’s written notes pertaining to sexual behavior, disclosure counseling and information about the names or the number of sexual partners. Or a Crown attorney may refer to a case management file as evidence that a defendant was aware of his or her obligation to disclose under the criminal law. Furthermore, public health nurses have been summonsed as witnesses against their clients, being asked to testify about the details and accuracy of their written counseling notes. Several nurses in the current study confirmed that their health departments had received requests from police or courts for health records in the recent past, though not all instances resulted in a criminal trial or prosecution.

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