# Disclosure of HIV-Positive Status To Sexual and Drug-Injecting Partners:

## A Resource Document

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**Prepared for the Ontario Advisory Committee on HIV/AIDS (OACHA)**

# Acknowledgements

This resource document was prepared under the direction of the **Ontario Advisory Committee on HIV/AIDS (OACHA) Working Group on HIV Disclosure**. The paper was prepared with input from a broad range of HIV stakeholders including people living with HIV/AIDS, community-based AIDS organizations, public health staff, government representatives, physicians, and other health care workers. The OACHA HIV Disclosure Working Group includes:

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## Dedication

**Robert Trow**
November 23rd 1948 – October 21st 2002

This document is dedicated to the memory of Robert Trow, who died on October 21, 2002. Robert was an exemplary leader in the fight against HIV/AIDS. Among his many accomplishments, Robert was one of the early advocates and providers of anonymous HIV testing in Ontario. Besides being a member of the HIV Disclosure Working Group, Robert was a member of OACHA for more than 10 years, providing his expertise to countless other working groups.

In the words of one of Robert's closest friends, "the city, the province, the community has lost its most ardent, zany and irreverent crusader for people living with HIV/AIDS." Robert is, and always will be, sadly missed.

# Table of Contents

# 1. About This Document

The topic of disclosure of a person's HIV-positive status to another person has been the subject of discussion, debate and deliberation since the beginning of the AIDS epidemic.

In September of 1998, the Supreme Court of Canada released its first judgment dealing with the criminal prosecution of an HIV-positive person for engaging in sexual activity without disclosing his serostatus, ***R. v. Cuerrier.***[1] In this judgment, the Court concluded that an HIV-positive person who engaged in unprotected vaginal intercourse without disclosing his HIV status could be charged with assault, even if his partner willingly engaged in the sexual activity.

In response to the Supreme Court's decision in the *Cuerrier* case, Ontario's Chief Medical Officer of Health distributed a memorandum to all Medical Officers of Health (MOH) regarding the impact of the ruling on public health practices in Ontario, directing all public health staff conducting pre- and/or post-test HIV counselling to include "the need for [HIV-positive] individuals to disclose and not to lie about their HIV status to all sexual partners." The memorandum implied that the disclosure requirement extended to all sexual partners regardless of the risk associated with the sexual activity in question. As such, the directive went well beyond the obligation to disclose set out in Cuerrier (i.e. disclosure required where there is a "significant risk" of HIV transmission).

In response to the memorandum, the Ontario Advisory Committee on HIV/AIDS (OACHA) identified the need for comprehensive guidelines on disclosure of HIV-positive status for all frontline service providers conducting pre- and/or post-test HIV counselling and/or ongoing counselling of persons living with HIV/AIDS (PHAs).

A few agencies in Ontario that are involved in pre- and post-test HIV counselling and ongoing counselling of HIV-positive people have guidelines dealing with the issue of disclosure. The Ontario Anonymous Testing Guidelines include a short section addressing this issue. In addition, three community-based AIDS service organizations (ASOs) - Peterborough AIDS Resource Network (PARN), the AIDS Committee of Toronto (ACT) and the Kingston HIV/AIDS Regional Services (HARS) - currently have formal or draft policy statements related to the topic of disclosure.

OACHA recognizes the need for consistency in the effectiveness of counselling to support persons living with HIV/AIDS (PHAs) to address issues of disclosure of their HIV-positive status. Consistency of practice is also desirable across the many settings in which HIV counselling takes place in Ontario, so that agencies

[1] *Cuerrier* was the first such case to reach the Supreme Court of Canada, however it was not the first Canadian criminal case to deal with HIV transmission. Information about similar cases decided in other Canadian courts may be found at www.aidslaw.ca

and individuals can meet their legal obligations concerning protection and disclosure of information concerning HIV status. This document provides an overview of the complex issues related to disclosure of HIV-positive status and their impact on the counselling process. The document is intended to inform the development of counselling guidelines on disclosure of HIV-positive status that will protect and enhance good counselling practice across the province, affirm the health and human rights of PHAs and help reduce HIV transmission.

# 2. Definitions

## *2.1 HIV-Positive Status*

HIV-positive status is defined as infection with the Human Immunodeficiency Virus (HIV), as determined by a screening Elisa assay and a confirmatory Western Blot assay identifying the presence of antibodies to HIV. The presence of antibodies to some, but not all, HIV proteins (as, for example, those generated by experimental vaccines aimed at preventing HIV infection) does not constitute HIV-positive status.

## *2.2 Disclosure*

Disclosure is defined as the act of informing another person or persons of the HIV-positive status of an individual. An act of disclosure may be done by the PHA him/herself or by another person, with or without the consent of the PHA.

Disclosure can occur in many contexts: disclosure within personal relationships (to lovers, partners, spouses, children, friends and other family); disclosure in the workplace (to an employer, other employees, clients); disclosure to health and other service providers (physicians, emergency services, dentists, social workers, insurers, etc.); disclosure in an institutional setting (prisons, schools, etc.), and disclosure to the general public via the media.

While the information contained in this document may be relevant or useful in other contexts where disclosure may occur, its ***focus is on self-disclosure to sexual and drug-injecting partners***, due to the significant potential for HIV transmission to occur in these settings and the legal and ethical obligations to disclose under certain circumstances. Although there may be a significant potential for HIV transmission to occur in other settings (such as physical contact between health care workers or emergency services personnel and the body fluids of a PHA), the proper observation of Universal Precautions precludes the necessity to disclose in most circumstances.

### *2.3 Counselling*

Counselling is defined as the process of providing information, education, problem-solving, therapeutic interventions and support through a safe, confidential, non-sexual, professional relationship aimed at increasing the capacity of individuals to cope with, understand or overcome difficulties they are experiencing in their lives.

A counsellor in the context of this document is defined as any service provider who is conducting either pre- and/or post-test HIV counselling and/or counselling to HIV-positive people. In Ontario, public health nurses, physicians, social workers, counsellors in ASOs and other community-based organizations, psychologists, counsellors, peer counsellors and psychotherapists in private practice conduct these types of counselling.

### *2.4 Client*

A client is defined as any person seen by a counsellor in a professional capacity and to whom professional counselling services are provided. This may include one-time counselling sessions and/or counselling relationships involving multiple sessions.

### *2.5 Agency*

An agency is defined as any setting where pre- and/or post-test HIV counselling and/or ongoing counselling for PHAs is provided, including anonymous testing sites, public health units, community health centres, hospitals, clinics, ASOs and other community-based organizations, and the private offices of physicians, psychologists, counsellors and psychotherapists.

## 3. Assumptions

### *3.1 Disclosure is an Intimate Act*

Any disclosure of oneself engages the body, mind and soul. Vulnerabilities are engaged. Self image, self perception and self confidence issues will be brought forward and, dependent upon comfort and skill, will be managed within the discloser's frames of reference for life meaning. It should be anticipated that self-protection, healthy denial and fear may be present when discussing a person's erotic and drug using life in relation to HIV.

## *3.2 Disclosure Is Difficult*

Disclosure of one's HIV-positive status can be extremely difficult for PHAs. Counsellors need to be aware of all the psychosocial factors influencing a person's decision to disclose or not disclose his or her HIV-positive status.

### *3.2.1 Disease and Stigma*

In our society, many people are reluctant to confront their own mortality. Disease and death are often feared. Consequently, there is often stigma associated with having any disease, particularly a life-threatening, communicable disease. Since HIV infection is often associated with particular sexual and drug-related activities, stigmatization of PHAs is common. Disclosure can expose PHAs directly or indirectly to discrimination or rejection by family, friends and community.

### *3.2.2 Marginalization*

HIV/AIDS disproportionately affects already marginalized individuals (such as gay men, drug users, immigrants from endemic countries, etc.), some of whom may be even further ostracized if they disclose their status.

### *3.2.3 Violence and Fear of Violence*

A number of studies have shown that fear of violence can have a strong impact on the decision to disclose or not, particularly amongst some HIV-positive women in relation to their male sexual or drug-injecting partners.[2]

### *3.2.4 Homophobia*

Several studies of gay and bisexual men have demonstrated that internalized homophobia, isolation from the gay community, lack of acculturation to the majority culture, and being "in the closet" can have a negative impact on some men's decisions about whether to disclose to sexual partners.[3, 4, 5]

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[2] Gielen, A., O'Campo, P., Faden, R., Eke, A. Women's disclosure of HIV status: experiences of mistreatment and violence in an urban setting.
Women Health 1997.

[3] Kennamer, J., Honnold, J., Bradford, J., Hendricks, M. Differences in disclosure of sexuality among African American and White gay/bisexual men: implications for HIV/AIDS prevention.
AIDS Education Prevention 2000.

[4] Ratti, R., Bakeman, R., Peterson, J. Correlates of high-risk sexual behaviour among Canadian men of South Asian and European origin who have sex with men.
AIDS Care 2000

[5] Wolitski, R., Rietmeijer, C., Goldbaum, G., Wilson, R. HIV disclosure among gay /bisexual men in four American cities: general patterns and relation to sexual practices. AIDS Care 1998.

### *3.2.5 The Timing of Disclosure*

The ability to disclose can be affected by erotic arousal. The release of chemicals in the body during erotic arousal can change perception, cognition and boundary setting. An intense pre-orgasmic state will strongly impact the ability to disclose. Both the psyche and the body are in harmony and focused on building sensuality and not cognition. It is therefore likely that disclosure will be easier before intense erotic arousal.

The ability to disclose one's HIV-positive status can be related to the degree to which an individual has accepted his or her HIV diagnosis. It is often most difficult to disclose recently after diagnosis, when a person is grappling with the initial impact of his or her seropositivity.

In a 1998 study of homosexual and bisexual men, researchers found that initially after an HIV diagnosis, most of the men were reluctant and fearful of disclosing their HIV-positive status to others. They used this period as an opportunity to come to terms with their diagnosis before having to contend with the reactions of others. After this phase, there was evidence that disclosure was increasingly used as a mechanism for coping with the disease. Disclosure was used to increase both practical and emotional support, share responsibility for sex and to facilitate self-acceptance.[6]

### *3.2.6 The Context of Disclosure*

Disclosure may be easier or more difficult depending on the context in which it takes place. In many cases, disclosure to potential sexual partners may be more difficult than to trusted friends or family, due to fears of rejection. Some reports have suggested that disclosure to potential anonymous sexual partners may be more difficult due to the environments in which anonymous sex takes place, which often are not conducive to conversation. In these environments, people may tend to rely on non-verbal disclosure signals, which may not be accurate (e.g. the assumption by an HIV-positive gay man that if another man wishes to engage in anonymous unprotected intercourse he is also HIV-positive, or the assumption by an HIV-negative man that if another man wishes to engage in anonymous unprotected intercourse he is also HIV-negative).

## *3.3 Disclosure Can Help Reduce Stigma*

There is evidence to suggest that disclosure can help reduce the stigma associated with HIV/AIDS, both for the HIV-positive person and for others. The public disclosure of his HIV-positive status by basketball star Magic Johnson in 1991 resulted in dramatic increases in demand for HIV testing and counselling

[6] Holt, R., Vedhara, K., Nott, K., Holmes, J., Snow, M. The role of disclosure in coping with HIV infection.
AIDS Care 1998.

and in public awareness and sensitivity to HIV/AIDS that were sustained after one year of follow-up.[7]

It is likely that the cumulative effect of increased disclosure of HIV-positive status across society will further reduce the stigma associated with HIV/AIDS. This was the intention of the International AIDS Conference, held in South Africa in 2000, the theme of which was "Break The Silence".

## *3.4 Counselling Can Facilitate Increased Confidence to Disclose*

There is evidence that counselling can help increase the frequency of disclosure to sexual partners. One study of 255 men found that men who reported being counselled about disclosure at post-test and at their current HIV clinic, were more likely to have disclosed to sexual partners than men counselled only at post-test, only at the HIV clinic, or not counselled at either site. Disclosure increased with the number of times counselled at the HIV clinic.[8]

## *3.5 PHAs Should Control Disclosure of Their HIV-Positive Status*

Disclosure of a person's HIV-positive status to another person should be made by the individual himself or herself. OACHA assumes that all counsellors will strive to protect the privacy of a client's HIV-positive status.

## *3.6 Contact Tracing is Not Disclosure*

Contact tracing (or partner notification) has been defined as "the spectrum of public health activities in which sexual and injection equipment-sharing partners of individuals with HIV infection are notified, counselled about their exposure and offered services" (Jürgens, 1998). In Ontario, local public health units are responsible for performing contact tracing under a mandatory guideline published by the Ministry of Health and Long Term Care.

Persons diagnosed with HIV are encouraged to contact anyone with whom they have, prior to their HIV infection (or, if approximate time of infection is not known, as far back as 1981):

- Had unprotected penetrative sex or shared needles;
- Had frequent protected penetrative sex;

[7] Tesoriero, J., Sorin, M., Burrows, K., LaChance-McCullough, M. Harnessing the heightened public awareness of celebrity disclosures: "Magic" and "Cookie" Johnson and HIV Testing. AIDS Education and Prevention 1995.

[8] De Rosa, C., Marks, G. Preventive counselling of HIV-positive men and self-disclosure of serostatus to sex partners: new opportunities for prevention. Health Psychology 1998.

- Had any sexual or drug use activity where the risk is uncertain.[9]

If there are partners that the HIV-positive person does not want to contact him or herself, a list of their names and contact details can be given to a public health nurse who is then responsible for notifying the partners. The nurses who perform contact tracing should not communicate the name of the HIV-positive person or any other identifying information. Contact tracing by a public health nurse is therefore not to be confused with disclosure.[10] It should be noted, however, that involuntary disclosure sometimes occurs if sexual or drug-injecting partners contacted have had a small number of partners and can therefore deduce the identity of the PHA.

## *3.7 The Ethical Obligation of Individuals with Communicable Diseases to Protect Others from Infection*

In a civil society, it is generally agreed that individuals who are aware that they have a communicable disease are ethically obliged to strive to protect others from infection wherever possible. OACHA affirms this ethical obligation of PHAs.

## *3.8 Persons with HIV/AIDS have a Right to Full, Active, Healthy and Self-determined Sexual Expression*

PHAs are entitled to a quality of life that includes sexual intimacy. Subsequent to diagnosis of HIV infection, the sexual expression of PHAs may undergo a series of changes that may benefit from counselling. OACHA affirms this position and assumes that it will be asserted in any counselling relationship.

## *3.9 The Majority of PHAs Strive to Protect Others from HIV Infection*

Although there has been no comprehensive research conducted in Ontario to quantify disclosure of HIV-positive status or explore the factors influencing disclosure or non-disclosure, some smaller studies across North America provide evidence that the majority of PHAs disclose their serostatus to sexual partners more often than not. No studies were found, however, that examined the issue of disclosure to drug-injecting partners.

One study of 203 patients in HIV primary care at two urban hospitals in the USA was conducted in 1998. Of the 203 study participants, 69% were men, 46% were African-American, 23% were Latino and 27% were White. In addition, 41% were injection drug users, 20% were homosexual or bisexual men, and 39%

[9] HIV Antibody Testing: Guidelines for Pre- and Post- Test Counselling in Anonymous Testing Ontario Ministry of Health, 1995.
[10] From Ontario Guidelines for Pre-and Post-Test Counselling in Anonymous Testing, 1995 (currently being updated).

reported they were infected through heterosexual sexual activity – a group reflecting the diverse demographics of PHAs. One hundred twenty-nine reported having one or more sexual partners during the previous six months. Of those, 60% had disclosed their HIV status to all sexual partners. Of the 40% who had not disclosed to all sexual partners, 57% reported using condoms less than "all the time".[11]

Another study of 147 mostly gay male PHAs at an HIV outpatient clinic in New Orleans found that 76% reported disclosing their HIV status to their last sexual partner. Approximately 23% reported not using a condom with a person to whom their status was not disclosed.[12]

## *3.10 A Significant Minority of PHAs Do Not Practice Safer Sex*

Despite evidence that the majority of PHAs either disclose to sexual partners, practice safer sex or both, the studies above provide evidence that a significant minority of PHAs continue to engage in sexual activities that place sexual partners at risk of HIV infection. In addition, recent epidemiological data in Ontario demonstrates an increase in HIV incidence in gay men.[13] As well, there is recent social research data suggesting increased rates of unprotected anal intercourse among gay men in a number of cities throughout the world.[14,15]

Opportunities and challenges exist for improved interventions with HIV-positive people to help reduce HIV transmission in our communities.

## *3.11 Counsellors May be Biased*

Counsellors need to be aware of their biases regarding sexual or drug-injecting behaviour. For example, a recently HIV-diagnosed gay man who has been sexually active for many years, whose sexual experiences have primarily been unprotected and anonymous, in venues where the conversation that takes place is minimal, is likely to have great difficulty disclosing his HIV-positive status to a potential partner. If the man's counsellor has a sexual history that primarily consists of monogamous relationships it may be very difficult to appreciate the difficulties the client is facing with disclosure. A 1998 American study of 309 marriage and family therapists, examining factors related to counsellors' breaking

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[11] Stein, M., Freedberg, K., Sullivan, L., Savetsky, J., Levenson, S., Hingson, R., Samet, J. Disclosure of HIV-Positive Status to Partners
Archives of Internal Medicine 1998.

[12] Niccolai, L., Dorst, D., Myers, L., Kissinger, PJ. Disclosure of HIV status to sexual partners: predictors and temporal patterns.
Sexually Transmitted Diseases 1999.

[13] Remis, R. HIV Incidence and Prevalence in Ontario, 2000.

[14] Osmond, D. Increased Rates of Unprotected Sex among San Francisco Gay Men.
University of California at San Francisco, 1998.

[15] Kippax, S. Gay Men and Unprotected Sex in Sydney, Australia.
National Centre in HIV Social Research, University of New South Wales, Australia, 2000.

confidentiality when HIV-positive clients' disclose high risk sexual behaviour, found that counsellors were more likely to disclose to a third party if the counsellor was older, female, had less experience with lesbian or gay populations, was Catholic or was very religious.[16]

# 4. HIV, Disclosure and The Law

## *4.1 Sources of Law*

Law is the attempt to define the rights and responsibilities of citizens in a given society and to name, categorize, and prescribe penalties for acts committed by an individual or groups of individuals that breach defined rights and/or ignore defined responsibilities.

Law is found in the statutes and regulations enacted by legislatures or their delegates, as well as in the decisions and interpretations of judges ("common law"). Rulings in individual cases involve the application and/or interpretation by judges of statutes and common law precedents set by other judges in previous cases of similar circumstances[17]. Judicial rulings can usually be reviewed by a higher court. The highest court in the Canadian judicial system is the Supreme Court of Canada.

The three areas of law that are pertinent to issues of HIV and disclosure are **criminal, civil and public health law.**

## *4.2 Criminal Law*

***Criminal law*** is found in statutes, primarily the ***Criminal Code of Canada***, which is a federal law applicable throughout the country. Courts interpret and apply the Criminal Code and other criminal statutes. To convict a person of a crime, the Crown (prosecution) must prove to a court "beyond reasonable doubt" that the person on trial committed the offence with which s/he has been charged. Historically, the criminal justice system has been punitive in nature, rather than preventive, as in the case of public health law, which is generally intended to be preventive.

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[16] Pais, S., Piercy, F., Miller, J. Factors related to family therapists' breaking confidence when clients disclose high-risks-to-HIV/AIDS sexual behaviours.
Journal of Marital and Family Therapy 1998.

[17] This is not so in civil law jurisdictions such as Quebec, where the decisions of higher courts are not technically binding on those below.

### *4.2.1 Criminal Law and HIV*

In Ontario's public health legislation, HIV is classified as the agent of a communicable sexually transmitted (venereal) disease. Until 1985, the ***Criminal Code*** made it a criminal offence for a person who was aware that he or she had a communicable venereal disease to transmit the disease to another person. This offence was repealed in 1985 on the policy ground that the transmission of disease was more appropriately dealt with by public health intervention rather than criminal prosecution.[18] Consequently, there is no criminal legislation in Canada that specifically applies to the act of knowingly transmitting or attempting to transmit HIV or other STDs. There has been much debate - both for and against - about including HIV-specific offences in criminal legislation, but no such changes to the Criminal Code have yet been made[19].

Although criminal charges against PHAs for the potential or actual transmission of HIV have been relatively rare in the past 20 years, such charges *have* been laid in the form of offences such as criminal negligence causing bodily harm, aggravated assault, aggravated sexual assault, administering a noxious substance and "being a common nuisance".

The applicability of the offence of common nuisance has been considered in at least one Ontario case involving HIV transmission[20]. In *Ssenyonga*, the charges of common nuisance were dismissed by the judge on the basis that having sex with specific individuals did not endanger the safety or health of "the public" (charges of *administering a noxious thing* were also dismissed). However, a Newfoundland court has subsequently ruled that a man accused of having unprotected sex with a woman without disclosing his HIV-positive status *could* be tried for the offence of common nuisance, finding that "specific individuals are members of the public and it matters not whether deliberate unprotected sex is had with one, one thousand or one million members"[21].

Prior to 1998, in two separate cases involving alleged *assault* (aggravated sexual assault and aggravated assault), the judge in each case acquitted the defendant on the basis that the complainant had freely and voluntarily engaged in sexual intercourse with the accused without the use of a condom[22]. Neither provincial court adjudicating these cases was willing to find that the consent to unprotected intercourse had been obtained by "fraud" (the alleged fraud being the non-

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[18] From Ontario Advisory Committee on HIV/AIDS. Reducing HIV Transmission by People with HIV who are Unwilling or Unable to take Appropriate Precautions 1997. See also Criminal Law and HIV/AIDS: Final Report, available at www.aidslaw.ca

[19] See Criminal Law and HIV/AIDS: Final Report, available at www.aidslaw.ca

[20] R. v. *Ssenyonga*, 1992, (1192) 73 C.C.C. (3d) 216.

[21] R. v. Hollihan, (1998) 171 Nfld. & P.E.I.R. 133.

[22] These two cases were among the first to consider the applicability of the charge of assault to apparently consensual sex, however earlier Canadian cases had considered the charge of assault and HIV transmission in the context of biting, spitting, etc.

disclosure by the accused of his HIV-positive status). In the case of aggravated assault, known as ***R v. Cuerrier***, the Crown appealed the acquittal to the BC Court of Appeal. The appellate justices unanimously dismissed the Crown's appeal. The Crown then proceeded with a further appeal to the Supreme Court of Canada.

### *4.2.2 The Supreme Court of Canada's Decision in R v. Cuerrier*

In September 1998 the Supreme Court ruled on the question whether non-disclosure of HIV-positive status to a potential sexual partner could constitute ***fraud***. All seven Supreme Court justices hearing the case concluded that it could. They were divided, however, as to how the law should define fraud that vitiates (invalidates) consent to sex. Ultimately, the majority decision of the Court created a new harm-based approach for deciding what will constitute fraud that invalidates consent to physical contact (including sex). To establish fraud on the part of the accused person which would render his or her partner's' consent legally invalid, the prosecution must prove the following:

- An act by the accused that a reasonable person would see as dishonest;
- A significant risk of serious bodily harm to the complainant as a result of that dishonesty;
- The complainant would not have consented but for the dishonesty of the accused.

The Court decided that ***non-disclosure of HIV-positive status constitutes "dishonesty"***, concluding that dishonesty in such circumstances does not just mean "deliberate deceit" about something, but can also include "non-disclosure" of information in circumstances where it would be viewed by a reasonable person as dishonest. Since non-disclosure of HIV-positive status can legally be considered "dishonesty" that amounts to fraud, it can invalidate consent to sex. The Court then turned to the question of ***when*** the duty to disclose arises. Non-disclosure cannot be considered dishonest unless there is a duty to disclose.

The Court determined that there is a duty to disclose when dishonesty (non-disclosure) results in ***"deprivation"***, which may consist of ***"actual harm or simply a risk of harm"***[23]. The ruling is clear that HIV-positive persons who do not disclose their status prior to engaging in sex, which carries a significant risk of transmitting HIV, may be convicted of assault (or sexual assault) even though the complainant did not actually become infected with HIV.

However, the Court was also clear that a trivial harm or trivial risk of harm would not be sufficient to satisfy this requirement. In ordering a new trial for the defendant, Cuerrier, on two charges of assault, the Court noted that "the Crown

[23] Excerpts from Elliott, R. After Cuerrier: Canadian Criminal Law and the Non-Disclosure of HIV-Positive Status, Canadian HIV/AIDS Legal Network 1999.

will have to establish that the dishonest act had the effect of exposing the person consenting to a ***significant risk of serious bodily harm***. The risk of contracting AIDS as a result of engaging in unprotected intercourse would clearly meet that test."[24]

The majority of the Court went on to say "to have intercourse with a person who is HIV-positive will always have risks. Absolutely safe sex may be impossible. ***Yet the careful use of condoms might be found to so reduce the risk of harm that it could no longer be considered significant so that there might not be either deprivation or risk of deprivation.*** To repeat, in circumstances such as those presented in this case, there must be a significant risk of bodily harm before the section can be satisfied. In the absence of those criteria, the duty to disclose will not arise." [25]

### *4.2.3 What the Cuerrier Decision Says Clearly*

People with HIV/AIDS who engage in insertive, unprotected vaginal or anal intercourse without prior disclosure of their HIV-positive status to their partner(s) may be convicted of aggravated assault[26], if charged.

### *4.2.4 What the* **Cuerrier** *Decision Doesn't Say Clearly*

***"Significant risk of serious bodily harm"*** was not clearly defined by the Supreme Court. As other cases arise, other judges will decide which activities constitute *"significant risk of serious bodily harm"* in the context of particular factual situations. Currently, it remains unclear in precisely which circumstances courts will find that a duty to disclose exists.[27]

### *4.2.5 Implications of the Cuerrier Decision on Counselling*

#### *4.2.5.1 Disclosure of HIV-Positive Status To Partners Prior to Unprotected Vaginal or Anal Intercourse or the Sharing of Uncleaned Drug-Injecting Equipment*

The Canadian AIDS Society (CAS) HIV Transmission Guidelines[28] are generally regarded as a primary resource in Canada regarding levels of risk of HIV transmission associated with sexual and drug-injecting activities. According to

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[24] Ibid.
[25] Ibid.
[26] Aggravated assault is a serious form of assault that carries a maximum sentence of fourteen years imprisonment.
[27] However, there is one New Brunswick case, R. v. Jones (2002, unreported), that states that it is not an offence to fail to disclose one's Hepatitis C positive status to sexual partners.

[28] McClure, C., Grubb, I. HIV Transmission Guidelines. Canadian AIDS Society, 1998.

the most recent CAS Guidelines (1999), the sexual and drug-injecting activities associated with high risk of HIV transmission are:

- Insertive and receptive vaginal or anal intercourse without a condom, and
- Injection using shared, uncleaned needle and/or syringe and/or mixing equipment.

In future, it is likely that courts will consider a range of evidence when considering the risks of transmission posed to sexual partners by various sexual acts. Until otherwise clarified by the courts, it is likely that the acts listed above would be considered by the courts to carry a *"significant risk of serious bodily harm"*, the term used in the Supreme Court of Canada's judgment in the case ***R v Cuerrier***.

Counsellors should make clients aware of their legal obligation to disclose their HIV-positive status to sexual partners prior to engaging in unprotected anal or vaginal intercourse. Whether a duty to disclose arises prior to other sexual activities, such as unprotected oral sex, is unclear. The most recent CAS Guidelines classify unprotected oral sex as "low risk". Although HIV transmission is known to have occurred through oral sex (fellatio), the number of cases remains low and appears to be restricted to specific circumstances where trauma has occurred to the mucous membranes in the mouth and/or throat.

*Cuerrier* does not specifically address the sharing of cleaned or uncleaned needles, syringes or mixing equipment. However, the general harm-based approach used by the Court is readily applicable to risk-bearing situations other than sexual activities, and may also be applicable to other sexually transmitted diseases, such as Hepatitis B (HBV) and Hepatitis C (HCV).[29]

The Canadian HIV/AIDS Legal Network's legal analysis of the *Cuerrier* decision concludes that a PHA who does not disclose his or her status and who *directly injects another person* with shared, uncleaned equipment after injecting him or herself, may be liable to criminal charges of assault. However, if the partner *injects himself or herself* with the shared, uncleaned equipment after it has been used by the HIV-positive person, then the HIV-positive person (i.e. first injector) who does not disclose would likely not be subject to an assault charge but may be subject to other criminal charges (such as criminal negligence causing bodily harm). It is also unclear whether cleaning injecting equipment would constitute a reduction in risk below the level of *"significant"*.[30] The current CAS Guidelines classify the act of sharing cleaned injecting equipment as *"low risk"*.

[29] However, see R. v. Jones, above.
[30] Elliott, R. After Cuerrier: Canadian Criminal Law and the Non-Disclosure of HIV-Positive Status Canadian HIV/AIDS Legal Network 1999, pp37-38.

In light of the *Cuerrier* decision, counsellors must inform their clients that failing to disclose their HIV-positive status prior to engaging in unprotected vaginal or anal intercourse is an offence in Canada. Counsellors should also inform their clients that failing to disclose their HIV-positive status before any other sex acts, or before sharing uncleaned drug-injecting equipment may also result in criminal charges being laid. In addition, counsellors should inform their clients that the risk of HIV transmission from low risk sexual or drug-injecting activities may be increased by a number of other factors (see CAS Guidelines).

#### *4.2.5.2 Disclosure of HIV-Positive Status Prior to Any Sex?*

Counsellors should discuss the ambiguities of the *Cuerrier* ruling regarding the exact meaning of the term *"significant risk of serious bodily harm"*. Until the term is clearly defined by Parliament or by the courts, non-disclosure of HIV-positive status to sexual partners prior to engaging in ***any*** sexual activity could theoretically result in the laying of criminal charges. It would appear that charges that relate to activities posing a relatively low risk of HIV transmission may be less likely to be laid or to result in conviction, but this has yet to be tested in the courts. Furthermore, *"significant risk of serious bodily harm"* will not be measured only by the likelihood the harm will materialize (i.e. that HIV will be transmitted), but also by the seriousness of the consequences if the harm materializes (i.e. infection with HIV is a very serious harm).

It is important to note that the focus of counselling around disclosure should be on the importance of reducing the risk that an HIV-positive person will expose a sexual or drug-injecting partner to HIV, rather than on the risk that criminal charges might be laid.

#### *4.2.5.3 Disclosure of HIV-Positive Status Prior To Sharing Cleaned Drug-Injecting Equipment?*

Counsellors should also inform their clients that until *"significant risk of serious bodily harm"* is clearly defined, non-disclosure of HIV-positive status prior to sharing of needles, syringes or mixing equipment cleaned with bleach does not eliminate the risk of exposure to a drug-injecting partner, and may also result in the laying of criminal charges. Again, it would appear that these charges may be less likely to result in conviction, but this has yet to be tested in the courts.

#### *4.2.5.4 HIV-Positive Mothers and Breastfeeding*

Because of the complexity of issues relating to maternal transmission, the current CAS' Guidelines do not classify the risk of HIV transmission through breastfeeding within the risk model of "no, negligible, low or high risk", but advise HIV-positive mothers against breastfeeding.

The Canadian HIV/AIDS Legal Network's analysis of the *Cuerrier* decision considers the potential for assault charges to be laid against HIV-positive mothers who breastfeed their infants, concluding that this will not be resolved until a more precise definition of *"significant risk of serious bodily harm"* is determined by the courts.[31]

In practice, the more pressing legal issue involves the potential seizure of the child of an HIV-positive mother pursuant to the Ontario *Child and Family Services Act*. The Act allows the Children's Aid Society (CAS) to intervene if it believes a child is "in need of protection". At least one case of CAS intervention has already occurred in the case of an HIV-positive mother who refused to allow administration of AZT to her newborn child. It is possible that an HIV-positive mother who insisted on breastfeeding her baby might also be regarded as placing the child in need of protection. Furthermore, it is important to note that the Act requires any person with knowledge of a child in need of protection to report the matter.

Counsellors should advise HIV-positive mothers to refrain from breastfeeding and inform them not only that breastfeeding carries the risk of HIV transmission and criminal charges, but that the counsellor is required by law to report such cases to Children's Aid.

#### *4.2.5.5 Does Cuerrier Oblige Counsellors to Inform the Police if a Client Does Not Disclose Prior to Engaging in High Risk Sex or Injection Drug Use?*

No. There is no ***statutory*** obligation to provide any client information to the police under any circumstances. (In the case of children who are deemed to be in need of protection, the duty is to report it to the Children's Aid Society, not to the police.) However, theoretically counsellors may be required under a court order, search warrant, subpoena or other judicial process to provide the police with information about clients. Counsellors cannot be criminally charged for failing to warn the sex or drug-injecting partners of a client that the client is HIV-positive.[32]

## *4.3 Public Health Law*

***Public Health Law*** aims to protect the health of the general public. It is widely agreed that the prevention of transmission of HIV/AIDS is primarily a public health issue and should be handled as a matter of public health rather than criminal law as far as possible.[33] The OACHA working group on reducing HIV

[31] Ibid, p 43.
[32] Ibid. p.59.
[33] Culver, K. Persons Unwilling or Unable to Prevent HIV Transmission: A Legislative Analysis and Literature Review. Federal/Provincial/Territorial Advisory Committee on AIDS 2000.

transmission by people unwilling or unable to take precautions believes that attempts to criminalize HIV transmission can harm prevention efforts and increase the stigma associated with living with HIV/AIDS.[34]

### *4.3.1 The Ontario Health Protection and Promotion Act (HPPA)*

The authority of the Ministry of Health and Long-Term Care in Ontario to act to attempt to prevent or minimize the spread of HIV is established by the Health Protection and Promotion Act (HPPA). Under the HPPA's regulations, AIDS is designated as both a reportable and a communicable disease. HIV is considered an "agent" of the communicable disease AIDS.

### *4.3.2 Legal Requirements for HIV Testing*

Two types of HIV testing are formally permitted under the HPPA: nominal (by name) and anonymous testing. Under the HPPA, the names of individuals who test HIV-positive must be reported to the local public health unit. However, there is a regulation under the HPPA that exempts anonymous test sites from the obligation to report.

#### *4.3.2.1 Post-Test Counselling for Anonymous Testing*

Ontario's Guidelines for Pre- and Post-Test HIV Counselling at Anonymous Test Sites require that counselling must include informing the client of his/her legal obligation to refrain from unprotected intercourse or the sharing of injecting equipment in the event that the test result is HIV-positive. The counselling must also advise the client (if s/he tests HIV-positive) to contact all persons who have engaged with him/her in unprotected intercourse or the sharing of injecting equipment and all frequent sexual partners prior to the time of HIV infection (whether intercourse was protected or unprotected). If the client is uncomfortable contacting any or all of his/her previous sexual or drug-injecting partners, s/he may provide a list of names and contact details to the counsellor, who will then forward it to a public health nurse without any personal identifying information about the HIV-positive client. The public health nurse will then contact the names on the list to inform them that a previous sexual or drug-injecting partner has tested HIV-positive and offer them the opportunity to come forward for HIV antibody testing.

In Ontario, a mandatory guideline requires local public health units to perform contact tracing (or partner notification) for a number of different STDs, including

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[34] Author unknown Reducing HIV Transmission by People Unwilling or Unable to take Precautions
Ontario Advisory Committee on HIV/AIDS 1997.

HIV. The guideline allows the public health unit to delegate this responsibility to physicians, but only if the physician consents.

The HPPA also authorizes public health officers to issue orders requiring that the person testing HIV-positive notify partners or requiring that person to provide names of sexual partners to public health for the purpose of contact tracing. However, in the absence of such an order, there is no general legal obligation for people who have tested HIV-positive in Ontario (or their physicians or counsellors) to contact past partners.

#### *4.3.2.2 Reporting Procedures in Nominal Testing*

In the case of nominal HIV testing, a copy of the test result is sent to the physician who ordered the test and, if the result is positive, another copy is sent to the Medical Officer of Health (MOH) of the regional health unit in which the physician is practicing. The MOH (or a designate) will initiate follow-up with the physician to ensure that the safer sex/injecting counselling and contact tracing described above have occurred. MOHs may conduct direct follow-up counselling of people who test HIV positive, and will definitely do so at the request of the physician.

#### *4.3.2.3 Non-Nominal Testing Allowed at the Discretion of the MOH*

A third type of testing – non-nominal testing – entails the linking of the identity of the person tested to a code known only to the physician and the person tested. Although non-nominal testing is not permitted by the HPPA, some MOHs allow non-nominal reporting if they are satisfied that safer sex/injecting counselling and contact tracing have occurred.

### ***4.3.3 HIV, Disclosure and the HPPA***

The topic of disclosure remains poorly outlined in most counselling guidelines in Ontario. Apart from partner notification requirements after diagnosis, there is no public health legislation requiring counsellors or physicians to address disclosure with their clients.

### ***4.3.4 Managing High Risk Behaviour: Section 22 Orders***

The HPPA provides for a number of responses to the reporting of suspected or actual high-risk behaviour (of a person who is actually or suspected to be HIV-positive) through the use of a Section 22 order. The Act does not require that actual transmission of HIV must take place before a Section 22 order can be issued by the MOH of the person's local health unit. The MOH must have "reasonable and probable grounds" that the requirements of the order are necessary to decrease or eliminate the risk of HIV transmission to a person or persons in the health unit served by the MOH.

#### *4.3.4.1 MOH Not Required to Inform Client Prior to Making Section 22 Order*

The MOH is not required to inform or interview the person prior to issuing the Section 22 order. The Act does not specify the process, which must be followed in carrying out the order, or list the precise behaviours, which will warrant the issuing of an order. In practice, the approaches taken by MOHs to Section 22 orders in Ontario usually begin with the least intrusive, least restrictive measures (i.e. voluntary counselling) and gradually increase in their level of intrusiveness and restriction of the person's freedom.

#### *4.3.4.2 Section 22 Order Takes Effect Immediately; Client May Subsequently Request Hearing in Writing Within 15 Days*

Although the written Section 22 order takes effect immediately, it must inform the person to whom it is directed that s/he is entitled to appeal the order to the Health Services Appeal and Review Board (HSARB). (To appeal, the person must submit written notice of appeal to the HSARB within 15 days after the order was served on the person.) The HSARB has the power to stay the order in question until the appeal is heard. The Board is technically required to hold the hearing within 15 days, although it has the power to extend the 15 day time limit. In practice, an initial "hearing" is usually held that is very preliminary in nature, and the substantive hearing takes place some months later. The person has the right to be represented by counsel and has the full opportunity to test the evidence of the MOH by cross-examination and to introduce his or her own evidence to challenge the order. The HSARB scrutinizes the evidence to determine whether it meets the requirements of the HPPA. The HSARB has broad powers to confirm, alter, or rescind the order. Finally, either the person or the MOH may appeal the decision of the HSARB to the Ontario Divisional Court.[35]

#### *4.3.4.3 How Does High Risk Behaviour Come to the Attention of Public Health?*

Reports of high risk behaviour by a person that may indicate HIV infection or the potential or likelihood that that person may transmit HIV to others can come to the attention of public health officials in a number of ways. These include public health follow-up of a person who has tested HIV-positive or in whom another sexually transmitted disease is diagnosed.

Subsection 34(1) of the HPPA requires physicians to report to the MOH "the name and residence address of any person who is under the care and treatment of the physician in respect of a communicable disease and who refuses or neglects to continue the treatment in a manner and to a degree satisfactory to

[35] Ibid.

the physician". This section does not refer to or require the reporting of a patient's high risk behaviour.

Section 34 of the HPPA addresses only physicians. The HPPA does not require any health care professional or counsellor other than a physician to report clients who "refuse or neglect to continue the treatment in a manner and to a degree satisfactory to the physician".

Paragraph 39(2)(c) of the HPPA permits physicians **and others** to breach client confidentiality "where the disclosure is made for the purposes of public health administration". In practice, many physicians call public health and discuss patients' high risk behaviours and are permitted to do so under this Section 39. However, being permitted to do something is not the same as having a positive obligation to do something. Physicians are under no positive obligation to report high risk behaviours to public health.

Past or current sexual or drug-injecting partners of a person known or suspected to be HIV-positive and known or suspected to be engaging in risky behaviour can also report their concerns directly to the MOH. The police sometimes notify public health in the event of a complaint from a member of the public.

### *4.3.5 Confidentiality under Public Health Law*

Section 39 of the HPPA prohibits disclosure by any person of identifying information (name, address and OHIP number) about a patient or client who has become a subject of the HPPA outside the reporting requirements of the Act. It does not impose a general duty of confidentiality on health care providers.

As mentioned above, paragraph 39(2)(c) of the HPPA permits physicians **and others** to breach client confidentiality "where the disclosure is made for the purposes of public health administration". In practice, many physicians call public health and discuss patients' high risk behaviours under this Section, although they are under no positive obligation to do so.

One of the strengths of the public health law under the HPPA is the legal requirement that the identity of any person issued with a Section 22 order, along with all information related to the case, must remain confidential. However, any information that has been gathered in a public health investigation can be released in a court of law if the prosecutor knows the information exists and subpoenas it.

Because a courtroom is a public forum, information related to any criminal proceeding (including a proceeding associated with HIV transmission), and any pleadings in a civil suit involving HIV, are accessible to the public. Although the file will remain open to the public, the Court may agree to a request for a non-disclosure order (a publication ban).

### *4.3.6 HIV-Specific Revisions to HPPA May Be Required*

OACHA is aware that if public health law in Ontario is to become truly effective at both encouraging disclosure of HIV-positive status and reducing HIV transmission, the HPPA should be revised to address HIV-specific issues with respect to dealing with those individuals unwilling and/or unable to protect sexual or drug-injecting partners from HIV transmission.

## *4.4 Civil Law*

***Civil Law*** is the area of law concerned with "private" liability between individuals. In civil proceedings (law suits), a person who is found to be negligent for not discharging a duty of care may be liable to pay financial compensation to an injured party, or be subject to other court orders or restraints.

In the context of HIV and disclosure, civil ***"tort" law*** is relevant to both the HIV-positive person's civil liability in relation to his or her sexual and/or drug-injecting partner, and the counsellor's or counselling agency's civil liability in relation to the client (the HIV-positive person) and/or the person infected or at risk of being infected.

### *4.4.1 Battery*

If failure to disclose HIV to a sexual partner can negate consent for criminal purposes (*Cuerrier)*, then it almost certainly does so for civil purposes. As a result, failure to disclose to sexual partners can result in an action in battery ("wrongful touching"), since a court may regard the unprotected sexual act as a form of "touching" to which there was no consent. As an intentional tort (wrong), battery, unlike negligence, does not require that the plaintiff prove damages (i.e. the transmission of HIV) and is therefore more likely to succeed than an action in negligence.

### *4.4.2 Negligence*

In civil law, for an action in negligence to lie, there must be a ***"duty of care"*** owed by the defendant to the person (the plaintiff) who is alleging the harm caused by the defendant's negligence***.*** A duty of care is said to arise whenever there is a relationship of proximity between the parties such that it is foreseeable that harm might occur to the plaintiff as a result of actions by the defendant. It is assumed that a duty of care will arise between PHAs and their sexual or drug-injecting partners in circumstances similar to the criminal ***Cuerrier*** case, i.e. when engaging in conduct with another person that presents a *significant risk of*

*serious bodily harm*. In other words, it is likely that a Canadian court would say that HIV-positive persons owe a duty of care to their sexual or injecting partners.

The content of the duty of care that is owed to another person is called "the standard of care". The standard of care depends on what the reasonable person would expect from the HIV-positive person in all circumstances of the case. In light of Cuerrier, a court would certainly say that the standard of care requires an HIV-positive person to disclose her or his HIV-positive status prior to unsafe sex or unsafe sharing of injection equipment. It remains an open question whether or not a court will say that the civil standard of care includes an obligation to disclose one's HIV-positive status before safe or very low risk sex.

For a person to be held liable in negligence and have to pay damages, there must be a breach of the standard of care. In addition, the plaintiff must show that the breach caused physical harm to the plaintiff.

### *4.4.3 Confidentiality*

#### *4.4.3.1 Duty to Maintain Confidentiality*

Counsellors who are members of regulated colleges (like nurses for example) have a statutory duty to maintain client confidentiality that is usually found in the regulations governing the counsellors' profession. There is also a common law duty owed by all counsellors and agencies to clients to maintain the confidentiality of their personal information. Breaches of confidentiality may result in civil actions for damages if harm (including financial harm) results to the client from the breaches of confidentiality. However, the tort of breach of confidentiality is not well developed in Ontario outside the context of commercial or trade secrets and a court may not accept it as a valid tort in these circumstances. Moreover, there may exist a defense against such actions if the disclosures were made "for the purposes of public health administration" (as Section 39 of the HPPA specifically authorises such disclosures).

In addition to the legal obligation to keep client information confidential, confidentiality is a fundamental ***ethical principle*** of counselling. This is discussed in the next section of the document.

In Ontario, the general duty of confidentiality for physicians is contained within Regulation 856/93 made pursuant to the *Medicine Act,* 1991; for nurses, Regulation 799/93 made pursuant to the *Nursing Act,* 1991; and for social workers registered with the Ontario College of Social Work, Regulation 384/00 pursuant to the *Social Work and Social Service Work Act* 1998. For unregistered social workers, the duty of confidentiality is limited to that imposed by the common law.

It is considered professional misconduct for a health care professional to disclose confidential information about a client to another person without the client's consent, except *"*as required or allowed by law*"*.[36] However, professional bodies, legislatures, and courts have recognized that, in some circumstances, confidentiality must give way in order to protect other, prevailing interests or to fulfill an over-riding duty to take reasonable steps for the protection of third parties.[37]

*4.4.3.2 Limits to Confidentiality*

The Canadian Medical Association and the Canadian Association of Social Workers advise physicians and social workers that disclosure to a spouse or sexual partner may be warranted when an HIV-positive client is unwilling to self-disclose, provided that the partner is at risk of HIV infection and the physician or social worker informs the client first of his or her intention to disclose to the partner. According to these professional guidelines, before breaching confidentiality, the physician or social worker should intervene through counselling and discussion of possible barriers to risk reduction in order to motivate the client to either disclose and/or to stop unsafe behaviour. If these interventions fail, the physician or social worker should report the situation to public health authorities.

In Ontario, Section 39 of the HPPA also permits physicians **and others** (potentially including counsellors and social workers at ASOs) to breach confidentiality "where the disclosure is made for the purposes of public health administration" (See 4.3.4.3 above).

*4.4.3.3 "The Public Safety Exception"*

In 1999, the Supreme Court of Canada ruled in ***Smith v. Jones*** that a ***"public safety exception" applies to "solicitor-client privilege",*** releasing the solicitor of the duty to protect the client's confidentiality. In that case, the Supreme Court said that "[solicitor-client] privilege is the highest privilege recognized by the courts. By necessary implication, if a public safety exception applies to solicitor-client privilege, it applies to all classifications of privileges and duties of confidentiality."[38]

The ruling suggests that the *"public safety exception"* to confidentiality would seem to release any counsellor or counselling agency from their civil duty to protect client confidentiality, if three factors are present:

- There is a clear risk of harm to an identifiable person or group of persons;

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[36] Unwilling Unable

[37] Elliott, R. *After Cuerrier*
Canadian HIV/AIDS Legal Network 1999

[38] Notes from Carey, R.
HIV/AIDS Legal Clinic of Ontario 2000

- There is a significant risk of serious bodily harm or death;
- There is imminent danger.

These three conditions would probably be met in the situation where an HIV-positive person refuses to disclose his or her serostatus to a sexual or drug-injecting partner(s), the partner(s) is/are identifiable to the counsellor, and the client clearly intends to continue to engage in unprotected intercourse or sharing of uncleaned drug-injecting equipment.

It is important to note, however, that even if all three conditions are present, the Court did not state that there was a positive obligation to disclose. There is simply the discretion to do so. Furthermore, the Court observed that "the disclosure of the privileged communication should generally be limited as much as possible."[39] In other words, if the discretion is exercised and a counsellor does disclose confidential information, only that information which is absolutely necessary to avoid the risk should be disclosed. In addition, the discretion to disclose created by the *"public safety exception"* does not relieve the counsellor from the obligation to first inform the client of his or her intention to breach confidentiality.

It is important for counsellors to understand that the issue of ***positive duties*** was not before the court. Therefore, this case can only be understood as providing a *"public safety exception"* that gives counsellors the ***discretion*** to disclose. It does not ***require*** them to do so.[40] However, it is possible that this duty could be imposed in a future case where the issue of positive duties is directly before the Court.

# 5. Ethical Principles and Practices of Counselling

A successful counselling relationship is dependent on the ability of the counsellor to create a ***safe, confidential, supportive environment*** for the client. In addition to the legal responsibilities of the counsellor, there are a number of fundamental ethical principles and practices that counsellors should follow. These should be regarded as applying ***even if the counsellor or counselling agency is not a member of a professional association or other body.***

## *5.1 Core Conditions of Counselling*

All client-centered approaches to counselling are based on the belief that each individual has the capacity to grow as a human being. Regardless of the circumstances in which clients present for counselling, a voluntary decision to seek counselling is a powerful statement of their desire to better understand their

[39] Ibid.
[40] Ibid.

thoughts, feelings or actions and their commitment to strive to overcome difficult issues they are facing in their lives.

Effective counselling requires the full engagement of the counsellor in the counselling relationship. Three core conditions of a successful counselling relationship have been described by Rogers and are the foundation of client-centered approaches to counselling.[41] These core conditions are unconditional positive regard, empathy, and genuineness. Skillful use of the core conditions is essential to helping HIV-positive clients address issues around disclosure.

### *5.1.1 Unconditional Positive Regard*

Unconditional positive regard is the principle that all people have value and are entitled to respect. It is often termed "being non-judgmental", but it does not mean condoning or accepting all behaviour on the part of the client (e.g. an HIV-positive person's non-disclosure of his/her HIV-positive status to sexual or drug-injecting partners). It is an attempt to demonstrate to the client that she or he has intrinsic value as a human being, regardless of any negative feelings, thoughts or behaviour.

### *5.1.2 Empathy*

Empathy is the attempt to understand and enter into another person's feelings. In counselling, it involves demonstrating an appreciation of the client's experience (e.g. the difficulties he or she has disclosing his or her HIV-positive status to others), even though the counsellor's approach in the client's situation may be different. To empathize is not the same as to sympathize. Sympathy is the expression of *sharing* the feelings of another person. To empathize is to value the importance the client is placing on a given situation or experience. Empathy must be communicated to the client by reflecting back the words or feelings that the client is expressing. The power of empathy is that it enables the client to feel that someone cares about what s/he is going through and recognizes the impact it is having on her/his life.

### *5.1.3 Genuineness*

The ability of the counsellor to be genuine demonstrates to the client that his/her thoughts, feelings and actions have a real impact on other people. Being genuine involves the counsellor's expression of his or her reaction to the thoughts, feelings or actions of the client ***in a non-judgmental, empathic way.*** This could mean, for example, expressing concern for the welfare of another person whom an HIV-positive client has put at risk by engaging in unprotected intercourse without disclosing his or her HIV-positive status.

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[41] Roger, C. Client-Centred Therapy.
Houghton Mifflin 1951.

## *5.2 Ethical Principles*

### *5.2.1 Confidentiality*

Confidentiality is as much an ethical principle of counselling as it is a legal obligation. Confidentiality recognizes the powerful role the counsellor plays in the client's life and enables the client to feel safe in expressing painful or difficult experiences.

A person who has either just been diagnosed with HIV, or has been living with HIV for some time, will often be working through issues such as shame, anger, sadness or fear. Deciding whether to disclose one's HIV-status, how and to whom, may evoke considerable anxiety. The knowledge and trust that information shared in the counselling relationship is confidential are crucial to helping the client resolve disclosure issues.

### *5.2.2 The "Duty To Warn"*

The codes of practice of virtually all counselling bodies throughout the world oblige counsellors to take all reasonable steps (including, where necessary, breaking confidentiality and/or directly warning the third party) to prevent a client from causing future harms to a third party identified to the counsellor by the client. Many codes of practice include in this obligation the client's threat to physically harm him or herself. The counsellor must ensure, to the best of his or her ability, that the threat to harm is legitimate and likely, and must inform the client of his/her intention to break confidentiality before warning the third party (unless of course, informing the client would render the warning to the third party ineffective).

Since unprotected intercourse or the sharing of uncleaned drug-injecting equipment by HIV-positive individuals carries a significant risk of serious bodily harm to another person, it would appear that the counsellor's ethical duty to warn applies ***when the person(s) at risk of harm is/are identified.*** It is unclear if this ethical principle applies when the person(s) at risk are not identified.

# 6. Resources for Clients

There is currently a paucity of clear, concise and user-friendly written information for persons living with HIV/AIDS concerning disclosure.

The HIV & AIDS Legal Clinic (Ontario) has produced a brief pamphlet outlining the legal ramifications of the Cuerrier decision entitled “Sex After Cuerrier”. The Canadian HIV/AIDS Legal Network has produced a series of 8 info-sheets on criminal law and HIV.

Two PHA-directed documents were found that offer concise, user-friendly information and advice on the topic of disclosure. Neither of these documents, however, outlines the legal obligations of PHAs to disclose their HIV-positive status to sexual and drug-injecting partners. The first is a 5-page document produced by the British Columbia Persons with AIDS Society in 1999, and is entitled “Relationships and Disclosure”. The second is a 2-page document written in Positively Aware, the journal of the U.S.-based Test Positive Aware Network, in 1998.

Although it is neither targeted specifically at PHAs nor contains information specific to disclosure of HIV-positive status, *Client Rights in Psychotherapy and Counselling*, produced in Ontario by the Client Rights Project in 1998, is an excellent handbook for clients seeking or engaged in a counselling relationship.

# 7. Resources for Service Providers/Agencies

The proposed OACHA guidelines for counsellors on disclosure to result from this current process of research and consultations will be made available as a resource for all service providers in Ontario.

Resources for service providers that are currently available, or in draft form include:

Hassle Free Agency Guidelines on Confidentiality of Personal Health Information and Record-Keeping (in production);
AIDS Committee of Toronto (ACT) disclosure policy (draft);
Kingston HIV/AIDS Regional Services (HARS) disclosure policy;
Peterborough AIDS Resource Network (PARN) disclosure discussion paper;
AIDS Calgary Awareness Briefing Document;
Federal/Provincial/Territorial Committee on HIV/AIDS (F/P/T) Unwilling/Unable Policy Guidelines (draft, not currently available);
Ontario Pre-Post Anonymous HIV Testing Counselling Guidelines;
Ontario Advisory Committee on HIV/AIDS (OACHA) Unwilling/Unable Document (currently being updated);
Canadian HIV/AIDS Legal Network, “After Cuerrier” Policy Analysis; Series of 8 Info-Sheets on Criminal Law and HIV/AIDS; Criminal Law and HIV/AIDS: Final Report. The Legal Network’s website at www.aidslaw.ca contains many useful resources relevant to this area.
Canadian AIDS Society HIV Transmission Guidelines;

Canadian Medical Association Counselling Guidelines for Human Immunodeficiency Virus Serologic Testing

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