

HIV Screening in Health Care Settings

Public Health and Civil Liberties in Conflict?

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ON SEPTEMBER 22, 2006, THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) issued a sweeping revision of its guidelines for human immunodeficiency virus (HIV) screening in health care settings¹ that reversed a decade-old approach to AIDS policy. Previous guidelines recommended HIV testing only for persons at high risk or in health care settings with high HIV prevalence,² which reflected a civil liberties approach that constrained testing with costly, cumbersome procedures for pretest counseling and written informed consent. Health care professionals often did not perform HIV screening due to financial or administrative burdens or because conducting risk assessments or discovering HIV prevalence in their facilities was impractical.

The new guidelines, which apply to all health care institutions in the public and private sectors (eg, emergency departments, inpatient services, public health and community clinics, primary care, and correctional health care), represent a radical departure. The CDC now recommends HIV screening for all individuals aged 13 to 64 years as a part of routine medical care irrespective of lifestyle, perceived risk, or local HIV prevalence.¹ The recommendations incorporate a concept known as “opt-out” testing, which notifies all patients that testing will be performed unless an individual explicitly declines. Although the CDC guidelines do not explicitly indicate how patients should be notified about testing, separate written informed consent would no longer be required, but rather general consent for medical care would be sufficient. Similarly, counseling would not be required with HIV diagnostic testing or as part of HIV screening programs.

Social and Historical Context: HIV Testing From the 1980s to Today

The HIV screening policy originated in the 1980s when the scientific and social context was markedly different than it is today. At that time, individuals were unlikely to benefit from HIV testing: treatments were rudimentary, offering prophylaxis against some opportunistic infections, but holding out little hope of a longer, healthier life. More striking were the social risks.³ Family and friends often ostracized persons living with HIV/AIDS; employers, landlords, and

insurers discriminated against them; and partners, or even members of the community, sometimes threatened them with violence. Policy makers criminalized HIV transmission and spoke about tattooing or quarantining persons with HIV infection, leading to fears of reprisal. Exclusion from school and other ordinary aspects of life symbolized the struggle for equality, as AIDS joined race, sex, and disability as part of the civil rights movement of the 1980s and 1990s. It was fully understandable given the negligible therapeutic benefits and the pronounced stigma, that the law would be structured to safeguard personal autonomy and privacy and to proscribe discrimination.

The civil rights paradigm that informed AIDS policy may no longer be justified given the transformative scientific and social developments over the last decade. Rapid testing now enables HIV test results to be available in 20 minutes, compared with 1 to 2 weeks previously. Highly active antiretroviral therapy (HAART) can extend the healthy life of people living with HIV/AIDS from less than 1 year to decades. Treatment and counseling can significantly reduce the spread of HIV in the population. HAART reduces viral load and thereby probably lowers the risk of HIV transmission. Furthermore, knowledge of HIV infection appears to reduce risk behavior, particularly if accompanied by prevention counseling. Researchers estimate that untested HIV-infected individuals are more than twice as likely to engage in high-risk sexual behavior⁴; people who are unaware of their infections are estimated to account for 50% to 70% of new sexually transmitted HIV infections. Further, health economists have suggested that HIV screening is cost-effective.⁵ This may be true even in low prevalence health care settings due to the substantial survival advantage resulting from earlier diagnosis. Screening for HIV thus stands out as paramount in treatment, prevention, and cost savings.

Stigma and discrimination remain a problem in contemporary culture, but not to the same degree as in previous times. Although socially disfavored groups such as racial and sexual minorities continue to bear a disproportionate burden of HIV infection, privacy and antidiscrimination laws are widespread at the federal and state level. In the new mi-

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lieu of personal therapeutic benefit, societal benefit, and fewer social risks, a public health strategy for the HIV epidemic appears warranted.

Epidemiology of HIV/AIDS: Further Justifications for the Public Health Model

Despite the increased attention to the AIDS epidemic worldwide, AIDS and HIV infection in the United States seem to have largely slipped from the attention and priorities of the public, the media, and policy makers. The sense of complacency may be due to the precipitous decline in AIDS cases and deaths in the United States since the widespread introduction of antiretroviral therapies in 1995. The annual AIDS mortality rate has, however, stabilized since 1999, and the proportion of cases among racial minorities has increased. At the same time, the incidence of new HIV infections remains high, with approximately 40 000 new infections occurring in the United States each year.^{6,7}

The primary justification for universal HIV screening is the large number of unrecognized infections. Researchers estimate that a quarter of the more than 1 million Americans living with HIV are unaware of their status.⁸ Moreover, nearly 40% of individuals who test positive for HIV are diagnosed with AIDS within 1 year after the test.¹ The problem is particularly acute among adolescents: more than 50% of HIV-infected adolescents are unaware of their HIV status,⁹ and up to 80% of HIV-infected young gay men are unaware of their HIV status.¹⁰ The large number of cases that are undiagnosed, or diagnosed late in the course of HIV disease, represents lost opportunities for linking people to medical care, reducing infectiousness, and encouraging safer behavior.

Medical and public health organizations, therefore, recommend universal HIV screening to foster earlier detection, identify and counsel persons with unrecognized infection, and link them to clinical and prevention services.^{11,12} Universal, as opposed to risk-based, screening also has the advantage of being less stigmatizing because it does not single out vulnerable populations and applies equally to all socioeconomic classes and racial groups.

Pregnant Women and Infants: An Illustration of Successful Routine HIV Screening

The discovery in 1994 that a regimen of zidovudine during pregnancy and childbirth could dramatically reduce perinatal transmission transformed HIV screening policy.¹³ The CDC responded to this study by issuing guidelines for counseling and screening in 1995.¹⁴ The following year Congress enacted a law encouraging routine screening, and New York mandated HIV screening of all newborns. In 1999, the Institute of Medicine made a bold proposal for routine universal screening of pregnant women,¹⁵ which led to a revision of the CDC prenatal testing guidelines in 2001. While the Institute of Medicine panel recommended “opt-out” voluntary testing, the CDC required written informed consent. The CDC streamlined the testing process in 2003.¹⁶

Routine prenatal HIV screening has been remarkably successful in preventing mother-to-child HIV transmission. The estimated number of infants born with HIV declined from a peak of approximately 1650 in 1991 to fewer than 240 each year today.¹ Perinatal transmission rates can be reduced to less than 2% with universal screening of pregnant women in combination with HAART, cesarean delivery, and avoidance of breastfeeding.¹⁷

The 2006 CDC guidelines embrace the concept of universal screening of pregnant women. Screening should now become part of a routine panel of prenatal tests unless the woman declines. No additional process or written consent is required for testing, but a patient’s decision not to be tested should be documented in the medical record. Abandoning the normal approach of nondirective counseling, the CDC recommends that health care professionals address a woman’s reasons for declining the test and inform her about the importance of testing. The CDC guidelines recommend repeat testing in the third trimester for all women in areas with high HIV prevalence, and the use of rapid HIV testing during labor. If the rapid test is positive, prophylaxis can be administered before a confirmatory test.

Barriers to Implementation: Legislation and Liability

Human immunodeficiency virus–specific legislation has been enacted in every state and the District of Columbia.¹⁸ State legislation, although highly disparate, could stand as a barrier to implementation of CDC guidelines.^{19,20} First, many laws stipulate who can perform testing, counseling, and partner notification services. Rigorous training and certification requirements could limit the capacity for hospitals and physician or dental offices to offer these services. Second, many laws explicitly require pretest counseling with prescribed content areas such as the uses and limits of the test, confidentiality assurances, transmission routes, symptoms of HIV disease, treatment options, and to whom the test results will be sent. Third, connected to pretest counseling, state law requires informed consent, often in writing and conforming to the content areas just discussed. And fourth, many states regulate posttest activities, such as by requiring confirmatory tests in licensed laboratories and face-to-face counseling. A few states even require education and counseling whether the test is positive or negative.

Many existing state laws clearly are inconsistent with CDC guidelines, raising a problem of federalism. Given the states’ primacy in infectious disease control, existing legislation is likely to control, but states may fear loss of CDC funding if they do not comply with national guidelines. If states do not reform their laws, they may pose insuperable obstacles to routine screening. State law reform, therefore, is critical if the CDC is to fully achieve its objectives. Federal/state partnerships to craft model legislation to harmonize AIDS policy would benefit all stakeholders, particularly if the government initiated a process of civic engagement with affected communities.

Tort liability for health care professionals poses yet another legal dilemma. If health care professionals do not offer testing in accordance with CDC policy, they could be found negligent. Damages could ensue if diagnosis was delayed or if the patient transmitted the infection to a sexual or needle-sharing partner. The Supreme Court has held that CDC guidelines have considerable weight in legal analyses.²¹ Conversely, if the health care professional does test a patient and knows that the patient's partners are at risk, the professional may have a duty to warn. Failure to protect known partners could result in liability.²² This is a double-edged sword for health care professionals, who ought to be guided to reduce tort liability risks.

Enduring Conflicts

AIDS policy has been mired in controversy since the earliest days of the epidemic.²³ Should the health system treat HIV differently than other diseases given the history of animus and discrimination? Alternatively, should HIV be incorporated into a standard public health model? "AIDS exceptionalism" can be seen in policies ranging from HIV testing and named reporting to partner notification—all of which have been viewed with suspicion for undermining privacy and autonomy.²⁴ AIDS advocates stress the value of individual rights, whereas health professionals stress the communal interests in prevention and treatment. The CDC, which for decades adopted a "rights" approach, is moving demonstrably toward public health. This can be seen in its support of reporting individuals with HIV to the health department by name, universal screening of pregnant women and infants, and now routine screening of the population. The CDC also plans to revisit its partner notification guidelines next year.

Certainly, AIDS advocates have muted their objections to routine testing as the benefits to their community have become more apparent. Nevertheless, the differences between the civil liberties and public health models endure. Although the CDC emphasizes the importance of respecting patient wishes, the guidelines leave open the possibility that individuals will be tested without their prior informed consent. Whether due to vulnerability, lack of initiative, lax hospital procedures, or cultural differences, some patients unknowingly will be tested for HIV. While the CDC properly recognizes the value of early diagnosis as a bridge to prevention and treatment, the guidelines do not provide a mechanism for posttest counseling and medical treatment. A diagnosis of HIV infection can have profound psychosocial effects, including the risk of suicide. Ensuring professional posttest counseling in a timely manner is vital for prevention and personal mental health. Furthermore, the CDC guidelines do not guarantee that patients will be able to access or receive medical treatment, which is important for the patient's benefit and for the wider society.

The AIDS policy debates have in many ways framed the discourse in modern society. The American polity has

sought, often in vain, to reconcile the difficult trade-offs between personal freedom and the common good. Perhaps this reflects a counterbalance to the civil rights approach of the late 20th century. For vulnerable communities, it may not be enough to focus absolutely on their rights, but also on their health and collective well-being. That may be the message of the evolution toward a public health model for combating HIV/AIDS.

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