

# REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS\*

CEJA Report 4-I-07

Subject: Amendment to Opinion E-2.23, "HIV Testing"

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Referred to: Reference Committee on Amendments to Constitution and Bylaws  
(Jane C.K. Fitch, MD, Chair)

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## 1 INTRODUCTION

2  
3 This report is submitted to update Ethical Opinion E-2.23, "HIV Testing," in response to  
4 Resolution 2-A-07, "HIV Testing," and Board of Trustees Report 1-A-07, "Ethical and Legal  
5 Issues in Responding to Occupational HIV Exposure." CEJA welcomes this opportunity to revisit  
6 its policies on HIV testing, especially in light of new guidelines published by the Centers for  
7 Disease Control and Prevention (CDC) that call for the general adoption of routine HIV testing.  
8 This Report provides guidelines in support of routine HIV testing while continuing to advocate for  
9 protection of patient autonomy and privacy.

## 10 11 EMERGENCE OF HIV INTERVENTIONS

12  
13 Traditionally, public health interventions for infectious diseases have included screening for  
14 infection, reporting infected persons to local public health authorities, and tracing the contacts of  
15 those exposed to infected individuals for purposes of notification, testing, and potential treatment.<sup>1</sup>  
16 However, reliance on these practices has historically been minimized in the treatment of  
17 HIV/AIDS due to the once prevailing attitude that HIV/AIDS represented a disease unlike other  
18 infectious diseases and therefore warranted exceptions from standard public health interventions.<sup>2</sup>

19  
20 One rationale supporting the differential treatment for HIV/AIDS was the fear that traditional public  
21 health interventions would be undermined by prevailing social circumstances. Unlike other  
22 infectious diseases that had been effectively treated through public health interventions, such as  
23 tuberculosis or smallpox, there was a palpable social stigma attached to persons infected with HIV,  
24 particularly among individuals belonging to certain disenfranchised populations.<sup>3</sup> Many  
25 individuals at high risk for contracting HIV feared that positive HIV test results would subject them  
26 to stigmatization and discrimination.<sup>4</sup> This perception was accentuated by the limited  
27 confidentiality protections afforded at that time. Public health officials therefore feared that  
28 patients might not seek HIV testing if confidentiality were not guaranteed.<sup>5</sup>

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\* Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 More significantly, the benefits to be derived through the application of traditional public health  
2 measures, such as routine screening, were largely outweighed by the potential harms to patients  
3 during the early years of the epidemic. Even if public health measures had been applied to HIV,  
4 they were not likely to have been effective. It was presumed that the difficulty of traditional  
5 contact tracing would render this approach ineffective.<sup>1</sup> Moreover, even if it were possible to  
6 identify HIV-infected individuals by way of routine screening or contact tracing, there was no  
7 effective treatment then available to afflicted individuals.<sup>6</sup> As a result, a positive HIV diagnosis  
8 was likely to have substantial psychological impact upon patients. From an ethical perspective, in  
9 the absence of effective therapies, the negative effects of the psychological consequences of HIV  
10 testing were not offset by sufficient positive benefit.<sup>6</sup>

11  
12 Policies were established during the early years of the epidemic directing that, with very limited  
13 exceptions, patients should only be tested for HIV with their informed, specific consent.<sup>6, 10</sup> In  
14 addition, procedures for HIV testing were instituted that placed a heavy emphasis on pre- and post-  
15 test counseling to minimize the psychological harms to patients and to promote patient education as  
16 a means of disease prevention.<sup>7</sup>

## 17 18 EVOLUTION OF HIV TESTING POLICIES

19  
20 As HIV has become less threatening in the public eye, the perceived need for additional  
21 requirements such as pre- and post-test counseling has decreased.<sup>6</sup> As a result, there is a  
22 willingness to consider traditional public health approaches such as screening, reporting, and  
23 partner notification to control the spread of HIV.<sup>1, 6</sup> Recent recommendations of the Centers for  
24 Disease Control and Prevention<sup>8</sup> stem from the increasing ability of public health measures to  
25 reduce rates of HIV infection. Rather than testing only individuals in high-risk demographic  
26 groups or pregnant women, the new guidelines call for routine HIV testing of all adults.<sup>8</sup> Tests for  
27 HIV are recommended to be conducted concurrent with other routine screening blood tests,  
28 meaning that some patients may ultimately be tested for HIV without their specific knowledge.<sup>9</sup>  
29 The CDC's guidelines additionally ease informed consent requirements by stating that patients'  
30 general consent for medical care sufficiently implies their consent to undergo routine HIV testing.<sup>8</sup>  
31 Accordingly, a separate written consent for HIV testing would no longer be needed.

32  
33 A substantial proportion of HIV positive patients are unaware of their carrier status, and expanding  
34 HIV screening may be appropriate both from a public health perspective<sup>10, 11</sup> and to better protect  
35 others from acquiring infection from those unknowingly affected. Furthermore, routine testing is  
36 likely to identify more affected individuals than targeted testing because many HIV-infected  
37 persons do not exhibit symptoms or report risky behaviors.<sup>12</sup> A recent analysis of the new CDC  
38 recommendations predicted that routine screening practices would prove clinically and  
39 economically effective so long as the rate of undiagnosed HIV infection is above 0.20%.<sup>12</sup>

## 40 41 INFORMED CONSENT WITHIN ROUTINE HIV TESTING

42  
43 Decisions regarding HIV testing and disclosure of source persons must consider issues relating to  
44 decisional autonomy, confidentiality, patient welfare, and clinical efficacy. In general, all patients  
45 must give their consent prior to undergoing any form of medical treatment (see Opinion E-8.08,

1 “Informed Consent”). For this reason, it is always preferable to seek patients’ voluntary  
2 participation in HIV, or any other, testing.

3  
4 As great emphasis had historically been placed upon informed consent,<sup>7</sup> CEJA has previously  
5 recommended that physicians ensure that HIV testing is conducted in a manner that respects patient  
6 autonomy by seeking the patient’s informed consent specific to HIV testing before testing is  
7 performed.<sup>13</sup> Currently, Opinion E-2.23, “HIV Testing,” emphasizes that the consent should not be  
8 derived from a general consent to treatment due to the need for pre-test counseling and the  
9 potential consequences of a positive HIV test upon an individual’s job, housing, insurability, and  
10 social relationships.

11  
12 Making HIV screening more routine would likely identify more infected individuals, especially  
13 those with early infection, minimal or no symptoms, and absent risk factors. This would lead to  
14 improved protections for uninfected individuals who might be subsequently exposed to these  
15 identified individuals. Routine screening might also help reduce the stigma associated with HIV if  
16 it were known that all patients were to be tested, as opposed to singling out individuals belonging  
17 to populations who have been historically associated with the epidemic.

18  
19 While routine testing should be encouraged, such a program should be implemented in a way that  
20 continues to respect patient autonomy. Respect for patient autonomy ideally calls for physicians to  
21 educate patients and seek their specific consent before performing any medical procedure,  
22 including diagnostic ones. However, this consent need not be in writing. In addition to testing all  
23 patients over the age of eighteen, the Institute of Medicine, the American College of Obstetricians  
24 and Gynecologists and the American Academy of Pediatrics specifically recommend universal HIV  
25 testing with patient notification as a routine component of prenatal care in order to decrease vertical  
26 transmission of HIV to neonates.<sup>14,15</sup>

27  
28 Beyond demonstrating respect for patient autonomy, effective communication between patients and  
29 physicians may help to increase the rate of voluntary HIV testing. By providing appropriate  
30 information, physicians can address many of the concerns that might otherwise lead patients to  
31 decline testing. Physicians can potentially allay fears of patients concerned about potential  
32 discrimination or stigmatization by assuring patients that many states have enacted strict consent  
33 and confidentiality requirements,<sup>16</sup> while federal regulations such as HIPAA provide effective  
34 privacy protections.<sup>9</sup> Physicians should also address patients’ fears regarding the test itself by  
35 emphasizing the improved accuracy of testing and the availability of effective antiretroviral  
36 treatments for patients identified as HIV-positive.

37  
38 Proper physician-patient communications and informed consent requirements can also constitute  
39 important means of promoting equality within the testing process. Without adequate informed  
40 consent requirements, vulnerable populations may be less able to opt out of testing, which could  
41 potentially lead to differential treatment. Patients’ perception of such differential treatment could  
42 erode their trust in the medical profession.

1 PREVENTION OF OCCUPATIONAL HIV TRANSMISSION

2  
3 Exceptions to standard informed consent requirements should only occur when the potential harm  
4 to patients' autonomy or privacy is balanced by potential benefit. For example, it can be ethical to  
5 test patients without prior consent when doing so is necessary to protect health care professionals  
6 who may have been occupationally exposed to HIV. Occupational exposure to infectious diseases  
7 can occur when health care personnel come into contact with infectious substances, such as blood,  
8 tissues, or specific bodily fluids belonging to an HIV-positive source-person. If a health care  
9 professional suspects that he or she has been occupationally exposed to HIV, it is imperative that  
10 he or she work with physicians or appropriate colleagues to assess the relative risks presented by  
11 disease exposure prior to initiating a prophylaxis regimen.<sup>17</sup> This risk assessment will require  
12 physicians to examine the source-person's HIV status. In such instances, it is always preferable to  
13 seek patients' voluntary disclosure of this information. However, if a patient is unwilling or unable  
14 to provide this information, mandatory HIV testing is ethically justifiable when the potential harms  
15 posed to exposed health care personnel outweigh concerns regarding patients' privacy and  
16 autonomy (see BOT Report 1-A-07).

17  
18 Likewise, it can also be appropriate to test physicians for HIV carrier status when necessary for  
19 patients' protection. Physicians performing exposure-prone procedures, such as invasive surgeries,  
20 must take appropriate precautions to avoid physician-to-patient transmission of HIV.<sup>8</sup>  
21 Accordingly, these physicians are ethically obligated to submit to periodic HIV testing.  
22 Seropositive physicians need not abandon their practice, but should make efforts to avoid engaging  
23 in exposure-prone procedures and further disclose their HIV status to patients when providing  
24 treatments that present a greater-than-average risk of transmission.<sup>18</sup>

25  
26 POST-TEST PROCEDURES

27  
28 Physicians' ethical obligations to promote patients' wellbeing require that they work to ensure that  
29 patients receive appropriate follow-up care upon receipt of a positive HIV test. As such, physicians  
30 should provide or otherwise assist patients in accessing post-test counseling and health services as  
31 necessary. To do so, physicians should make efforts to familiarize themselves with patient  
32 resources that may be available through the health system or other community organizations.

33  
34 In addition, physicians must comply with applicable disease reporting requirements. When doing  
35 so, physicians should protect the confidentiality of patients' medical information to the extent  
36 possible (see Opinion E-5.05, "Confidentiality"). This may be accomplished by divulging only the  
37 minimum amount of information necessary or by de-identifying information when possible.  
38 Physicians should also insist that involved public health workers be held to the same standards of  
39 confidentiality as are other health care professionals.

40  
41 Finally, physicians' ethical responsibility to protect the public requires that they take necessary  
42 precautions to prevent HIV-positive patients from infecting other individuals. If an HIV-positive  
43 individual poses an imminent threat of infecting an identifiable third party, the physician should:  
44 (1) notify the public health authorities, if required by law; (2) attempt to persuade the infected

1 patient to cease endangering the third party; and (3) if permitted by state law, notify the endangered  
2 third party without revealing the identity of the source person.<sup>13</sup>

3  
4 CONCLUSION

5  
6 The treatment of HIV has historically differed from the treatment of other contagious diseases,  
7 which for a long time was due to the limited treatment options and high mortality rate, as well as to  
8 the psychosocial concerns related to discrimination of minority patient groups. In recent years the  
9 potential harms associated with HIV testing have diminished relative to the potential benefits.  
10 Routine HIV testing presents an important means of promoting the public's health. However, it is  
11 still appropriate for doctors to seek patients' informed consent before HIV, or any other, tests are  
12 performed. By communicating effectively, engaging patients in the decision-making process,  
13 supporting the expansion of HIV screening programs, and providing appropriate follow-up care  
14 physicians may serve patients' best interests, help to protect the health of third parties, and achieve  
15 desired public health goals.

16  
17 RECOMMENDATION

18  
19 The Council on Ethical and Judicial Affairs recommends that the following be adopted and the  
20 remainder of the report be filed.

21  
22 E-2.23 HIV Testing

23  
24 Physicians' duties to promote patients' welfare and to improve the public's health are  
25 fostered by routinely testing their adult patients for HIV. Physicians must balance these  
26 obligations with their concurrent duties to their individual patients' best interest by  
27 following the guidelines below:

- 28  
29 (1) Physicians should support routine HIV testing procedures in order to protect patients,  
30 avoid injury to third parties, and promote public health.
- 31  
32 (2) While medical and social advances may have minimized the need for specific written  
33 consent prior to HIV testing, physicians should continue to seek patients' informed  
34 consent to undergo any form of medical treatment, including HIV testing. However,  
35 patients' consent does not need to be documented in writing. It is justifiable to test  
36 patients without prior consent only in limited cases where the harms to individual  
37 autonomy are offset by significant benefits to known third parties. Such exceptions  
38 include testing for the protection of occupationally-exposed health care professionals  
39 or patients.
- 40  
41 (3) Physicians must work to ensure that patients identified as being HIV positive receive  
42 appropriate follow-up care and counseling.
- 43

- 1 (4) Physicians must comply with all applicable disease reporting laws while taking  
2 appropriate measures to safeguard the confidentiality of patients' medical information  
3 to the extent possible.  
4
- 5 (5) Physicians must honor their obligation to promote the public's health by working to  
6 prevent HIV-positive individuals from infecting third parties within the constraints of  
7 the law. If an HIV-positive individual poses a significant threat of infecting an  
8 identifiable third party, the physician should: (1) notify the public health authorities, if  
9 required by law; (2) attempt to persuade the infected patient to cease endangering the  
10 third party; and (3) if permitted by state law, notify the endangered third party without  
11 revealing the identity of the source person.  
12
- 13 (New HOD/CEJA Policy)  
14
- 15 Issued March 1992 based on the report "Ethical Issues Involved in the Growing AIDS Crisis,"  
16 adopted December 1987 (JAMA. 1988; 259: 1360-61); Updated June 1994 and November 2008  
17 based on the report "HIV Testing."

Fiscal Note: Staff cost estimated at less than \$500 to implement.

REFERENCES

- <sup>1</sup> Bayer R. Public health policy and the AIDS epidemic: An end to HIV exceptionalism? *New England Journal of Medicine*. 1991; 324: 1500-04.
- <sup>2</sup> Lassarini Z. What lessons can we learn from the exceptionalism debate (finally)? *Journal of Law, Medicine, and Ethics*. 2001; 29:149-51/
- <sup>3</sup> Bayer, R. *Ethics and Infectious Disease Control: STDs, HIV, TB*. <http://www.asph.org/UserFiles/Module5.pdf> Accessed February 2007.
- <sup>4</sup> Richards E. HIV testing, screening and confidentiality: an American perspective. In: *HIV and AIDS testing, screening and confidentiality*. Oxford: Oxford University Press. 1999;75-90.
- <sup>5</sup> Bayer R, Levine C, Wolf SM. HIV antibody screening: An ethical framework for evaluating proposed programs. *JAMA*. 1986; 256:1768-74.
- <sup>6</sup> Bayer R. Clinical progress and the future of HIV exceptionalism. *Archives of Internal Medicine*. 1999;159:1042-48.
- <sup>7</sup> Bayer R, Fairchild AL. Changing the paradigm for HIV testing- The end of exceptionalism. *New England Journal of Medicine*. 2006; 355(7): 647-49.
- <sup>8</sup> Centers for Disease Control and Prevention. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *Morbidity and Mortality Weekly Report*. 2006;55(RR-14)::1-17.
- <sup>9</sup> Wynia K. Routine screening: Informed consent, stigma and the waning of HIV exceptionalism. *American Journal of Bioethics*. 2006;6(4):5-8.
- <sup>10</sup> Richards E. HIV testing, screening and confidentiality: an American perspective. In: *HIV and AIDS testing, screening and confidentiality*. Oxford: Oxford University Press. 1999;75-90.
- <sup>11</sup> Feffe D, Kahn SR, Meredith KL, et al. Disclosure of HIV status to medical providers: differences by gender, "race" and immune function. *Public Health Reports*. 2005;115:25-38.
- <sup>12</sup> Paltiel DA, Walenski RP, Schackman, BR, et al. Expanded HIV screening in the United States: Effect on clinical outcomes, HIV transmission, and costs. *Annals of Internal Medicine*. 2006;145(11):797-806.
- <sup>13</sup> AMA Council on Ethical and Judicial Affairs. Ethical Issues Involved in the Growing AIDS Crisis. *Journal of the American Medical Association*. 1988; 259: 1360-61.
- <sup>14</sup> Stoto MA, Almario DA, McCormick MC, eds. *Reducing the odds: Preventing perinatal transmission of HIV in the United States*. Washington, DC: National Academy Press. 1999. 109- 33.
- <sup>15</sup> American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Human immunodeficiency virus screening: Joint statement of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. *Pediatrics*. 1999; 104(1): 128.
- <sup>16</sup> Lawrence G, Hodge JG. The "names Debate": The care for national HIV reporting in the United States. *Albany Law Review*. 1998;61:679.
- <sup>17</sup> Campos-Outcalt D. HIV postexposure prophylaxis: Who should get it? *Journal of Family Practice*. 2006;55(7):600-4.
- <sup>18</sup> Tereskerz PM, Pearson RD, Jagger J. Infected physicians and invasive procedures: National policy and legal reality. *The Millbank Quarterly*. 1999; 77(4): 511-29.