

Virtual Mentor

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Ethical Decision Making in the diagnosis and Management of STDs

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Virtual Mentor

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From the Editor

Speaking of Sex

Few issues in health care arouse as much controversy as those associated with sexuality and sexually transmitted diseases (STDs). The prevention, diagnosis, and management of sexually transmitted diseases impacts individual patients and families, as well as the population as a whole. Politics, schools, the media, and public health systems all influence policies about STDs. This month *Virtual Mentor* explores some of the ethical issues surrounding STDs, such as confidentiality, stigma, and the exchange of information between physician and patient. Though some clinicians may be uncomfortable with this topic, STDs are not rare and can impact almost any age group or segment of the population.

We begin this issue with 3 clinical cases. In the commentary on the first case, David Cundiff illustrates strategies for managing a patient's request for confidentiality at the time a STD diagnosis is made. In Case 2, Ligia Peralta and Kathryn Conniff, as co-authors, and Christopher Kodama provide 2 perspectives on appropriate documentation of sexual risk factors in a patient's chart and address what is and is not clinically relevant information. In Case 3, Leslie Wolf explores how a medical student can address stigma about STDs when it is encountered in the hospital. These are scenarios that could happen in any hospital or clinic.

The clinical approach to STDs begins with taking a patient's sexual history. Many clinicians are uncomfortable with taking a detailed sexual history, and some even choose to avoid asking these personal questions, instead making assumptions based on the patient's age or socioeconomic status. In medical education, Ponrat Pakpreo reviews the importance of taking a thorough sexual history and lists its essential elements.

The diagnosis and management of STDs are continually evolving as new research discoveries are made. In a journal discussion, Abraham Schwab reviews a recent article by Matt Golden and Lisa Manhart that examined the advances in STD diagnosis and treatment. Jeffrey Klausner addresses the process by which emergent research leads to health policy changes in this month's policy forum, using the example of partner-delivered therapy for infections caused by *Chlamydia trachomatis*.

STDs affect individual patients, but they also impact populations. The prevalence of STDs within a population is affected by both demographic and cultural factors. Sevgi Aral explores these fascinating links in discussing the demographic transitions that contributed to the sexual practices of today. Laura McGough's medical humanities article illuminates the impact of stigma, a cultural force dating

back hundreds of years, on STDs. In the health law section Laura Lin and Bryan Liang grapple with the sometimes competing values of confidentiality, protection against discrimination, duty to warn, and protection of public health.

Prevention of STDs is a desired goal of patients, families, schools, and physicians. There is no consensus, however, from these diverse groups, about how best to direct efforts toward this goal. At present, the role of schools in prevention of STDs and teen pregnancy is a topic of much controversy. Advocates for abstinence-only and comprehensive sex education are both convinced that their methods provide superior prevention. In the medicine and society section of this issue, teacher Robynn Barth describes her own experiences “in the trenches,” teaching sex education in a rural middle school. Joe McIlhaney and Debra Hauser discuss pros and cons of abstinence-only education in schools, providing the 2 sides for our op-ed section.

Finally, a concern of almost all 3rd-year medical students beginning their clinical clerkships is the fear of sustaining a needlestick and subsequently contracting a STD or bloodborne illness. In the clinical pearl article, Josiah Penalver reviews the actual prevalence of this rare occurrence, the diseases associated with needlesticks, and the appropriate measures to pursue in the event of a needlestick injury.

Our hope is that this issue will provide readers with an ethical and historical grounding in issues concerning the care of patients with STDs. We also hope this month’s *VM* will offer readers an increased appreciation of the balance between patient and population connection and needs in the management of STDs.

The learning objectives for this issue are:

Recognize the limits to patient-physician confidentiality in the diagnosing and managing of patients with STDs.

Understand what constitutes appropriate documentation of sexual history, and learn how to interpret this information.

Understand the concerns of health care team members about interacting with patients with STDs and how to best approach these concerns to provide better patient care.

Learn the strengths and limitations of new strategies for diagnosing and managing STDs.

Learn about the ethical issues in HIV reporting and contact notification and the importance of knowing the laws about disclosure of HIV status in the state where you practice.

Megan A. Moreno, MD

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Clinical Case

The Wayward Husband

Commentary by Dave Cundiff, MD, MPH

Tom Covington arrived for an appointment with his primary physician, Dr Tony Charon. Tom explained that for the last week he had felt some burning when he urinated. Dr Charon asked some detailed questions; Tom's answers seemed vague and nonspecific.

Dr Charon ordered a series of tests, including a urinalysis and STD screening and placed Tom on presumptive antibiotic treatment. A few days later the tests came back positive for gonorrhea. Dr Charon called Tom back to the office to review the results. After Tom learned that he had gonorrhea, he explained sheepishly that he'd recently gone away on a business trip and confessed to a brief affair. He begged Dr Charon not to tell his wife about the infection. Dr Charon was conflicted about what to do, especially since he was also the primary physician for Tom's wife, Ann. He wondered whether he should maintain confidentiality or whether doing so would place Ann at risk.

Later that afternoon Dr Charon noticed that Ann had an urgent care appointment scheduled for the next day. "She may be coming in with similar symptoms," Dr Charon thought, "then I could legitimately test her for STDs." The next day Ann arrived for her appointment and explained that she had concerns about a sinus infection. She had had congestion, facial pain, and a mild fever for a few days. Dr Charon conducted an extensive review of symptoms. When asked about genitourinary symptoms, Ann answered "no" to all those suggestive of a STD. Dr Charon was unsure about the appropriate course of action.

Commentary

Dr Charon had good intentions throughout this episode, and he has done several things right. However, his implicit promise not to reveal Tom's diagnosis to anyone is a promise that he cannot keep, either ethically or legally. Dr Charon should not pursue this issue with Ann during this visit. He must use other means to protect both his patients, and an unknown number of people who were their sexual contacts, from an infection with serious consequences. He must act quickly.

Tom appeared embarrassed about sexual issues, giving "vague and nonspecific" responses in the initial interview. Dr Charon didn't succeed in resolving this vagueness. It isn't clear whether the missing data affected the accuracy of the presumptive diagnosis.

After a specific diagnosis was made, Tom recounted "a brief affair." Apparently the timing was consistent with gonorrhea's incubation period. Dr Charon allowed Tom to believe that they could keep this a secret from Ann. We don't know whether Tom had intercourse with Ann after the "affair," but Dr Charon thought Ann was at risk. He wanted to help Ann, but he didn't know how.

When Ann scheduled an appointment on her own, Dr Charon hoped he could address Ann's sexually transmitted infection (STI) risk without revealing Tom's secret. By the end of Ann's interview, it was clear that this strategy would not work.

Dr Charon must do something different and he knows he must do it soon, but he doesn't know what it is. He may have thought of questions like these:

1. Can the physician avoid full disclosure by treating Ann for gonorrhea, under the guise of treating her sinus symptoms?
2. Must physicians always preserve the patient's secrets?
3. Can other professionals help evaluate and treat patients with STIs appropriately?
4. What should be done next for Ann and Tom?
5. How difficult and time-consuming will this problem become?
6. How could STI issues be handled better next time?

Q. May the physician avoid full disclosure by treating Ann for gonorrhea, under the guise of treating her sinus symptoms?

A. No. This paternalistic deception would violate the *AMA Code of Medical Ethics*, which states:

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice.... The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice [1].

The *Code* also counsels: "... a physician should at all times deal honestly and openly with patients. Patients have a right to know their past and present medical status and to be free of any mistaken beliefs concerning their conditions" [2].

Deceiving Ann would postpone embarrassment for Dr Charon and for Tom at the expense of depriving Ann of the information she needs and deserves. Ann must discuss her recent sexual history and name any partners, so that all potentially infected persons can be diagnosed and treated. Why would she do that without knowing why a sexual history is being taken? Ann should report symptoms related to her diagnosis. How can she do that without knowing what the diagnosis is? Ann needs follow-up

testing. How can Dr Charon collect genitourinary specimens if Ann believes he is treating a sinus problem?

Ann and Tom would benefit from a shared understanding of, and a shared plan for, their marriage and family. Dr Charon cannot force this dialogue to occur, but he must refrain from deceptive actions that would harm this process.

Q. Must physicians always preserve the patient's secrets?

A. Physicians must understand the limits to confidentiality and must never promise more confidentiality than can be given.

The AMA's "Principles of Medical Ethics" provide that "[a] physician...shall safeguard patient confidences and privacy within the constraints of the law" [3]. When does the law require disclosure of confidential information without the patient's express or implied consent?

Laws and ethics require disclosure of information in certain dangerous situations. Evidence of child abuse or neglect and abuse or neglect of a vulnerable adult must be reported whenever required by law [4]. Evidence of a crime must be reported if the law requires. Physicians must also report a credible threat of injury to others [5]. Laws require reporting of public health concerns to public health authorities. Ethics require compliance with those reporting laws. Physicians must report gonorrhea in every US state.

Q. Can other professionals help evaluate and treat patients with STIs appropriately?

A. Public health authorities classically use "contact tracing" methods to bring STI contacts to evaluation and treatment without violating confidentiality. Persons reported to have STIs are interviewed promptly by public health disease investigators. These investigators are generally not licensed clinicians. They are trained in interviewing techniques, STI epidemiology, and how to maintain confidentiality while finding and protecting partners. Interviewing each confirmed patient, they take histories of all sexual experience relevant to the particular STI and determine how to locate the patient's recent sexual contacts. Contacts are told that they may have been exposed, without disclosing the index patient's identity, and are urged to seek examination and treatment. Some jurisdictions follow up with each contact as needed until medical evaluation is completed. Other jurisdictions are notified of out-of-area contacts if feasible.

The scope of this service varies greatly in different jurisdictions. Some departments use contact tracing for all gonorrhea cases. Other departments reserve contact tracing for a few selected situations or diagnoses. Because traditional partner notification is not always available or successful, public health researchers are exploring alternative strategies for promoting treatment of partners exposed to STIs [6].

Q. What should be done next for Ann and Tom?

A. Dr Charon should treat Ann appropriately for her sinus symptoms, answer her

questions, and end the visit as he normally would. He must then make sure that Tom's gonorrhea has been reported to the appropriate health department.

Dr Charon must talk with Tom again, preferably that day. Dr Charon must inform Tom that his right to confidentiality is not absolute. He must tell Tom that his illness has been reported to the health department as required by law. He should assure Tom that the health department will not reveal his name to others.

If Ann finds out about this situation from anyone but Tom, or if she is harmed by Tom's delay in telling her, the marital and legal consequences are likely to be much more severe than if Tom discloses promptly. Tom should be reminded of the potential harm from untreated gonorrhea. Whether or not Tom wants to stay married to Ann, he should be reminded that he has a legal obligation not to harm her. It is in Tom's long-term interest to treat Ann and other known partners with respect and to help each one to stay safe.

It may be best for Tom to reveal the situation to Ann himself. An objective third party (such as Dr Charon, if his schedule permits) may help Ann and Tom to process initial emotions. He should offer to refer the couple to one or more qualified marriage counselors if he thinks that is appropriate.

To protect her from additional risk, Ann must be notified immediately. If Tom will notify Ann outside the office, Dr Charon should know how and when Tom will discuss this. If either partner's history suggests a possibility of violence, a safe environment must be assured. In case Tom fails to notify Ann as agreed, Dr Charon should request permission to discuss Tom's diagnosis with Ann the next day. He should also urge Tom to notify his other partner if possible.

If Tom will notify Ann in the office, Dr Charon can influence the likelihood of success. Child care must be arranged if needed. There should be enough time to talk with both partners together. Ann must have time to speak privately with Dr Charon. She will probably want Tom to be out of the room when she is examined. If Ann has received antibiotics that might lead to a false-negative culture, at least one of Ann's diagnostic tests should be a DNA-based test. All patients with STIs should be encouraged to obtain appropriate tests for other STIs, including HIV.

Dr Charon should seek consultation if he needs it. Public health physicians are trained in a team approach to disease prevention and control. Dr Charon should request assistance if he is not qualified to handle the epidemiologic and emotional complexities of a case, if he lacks the time to address these complexities quickly and thoroughly, or if he is uncomfortable about the progress of the case. This consultation is available from the public health physician or other expert responsible for STI control in the city, county, or state. Public health consultation is not a violation of confidentiality.

Q. How difficult and time-consuming will this problem become?

A. Many things must be done quickly. Counseling, interviewing, and full sexual

histories can be difficult or impossible in a short appointment. Locating Tom's sex partner and, possibly, that person's sex partner(s), interviewing and counseling, and convincing them to seek treatment involve skills and time beyond that of the office setting. Barriers to interviewing, testing, and treatment can involve mistrust of interviewers or authority figures; disbelief or denial; excessive anger or fear; lack of knowledge about STI's; or financial, language, and transportation concerns.

Sexual networks are often complex. Tom's sexual network includes Tom and Ann plus the presumed source case for Tom's infection. This person may or may not be the source and may live in another area. That person has a sexual network of her or his own. She or he may have asymptomatic gonorrhea.

Will Tom contact this partner immediately? In light of his attempt to hide his behavior from both his physician and his wife, one wonders. Others are at risk besides Ann. Timely support from well-trained specialists, such as health department disease investigators, can be crucial.

Q. How could STI problems be handled better next time?

A. After resolving this episode, Dr Charon should have a working relationship with his public health department and its STI services. He should know whom to call for STI consultation, epidemiologic analysis, and disease control interventions.

When the crisis has passed, Dr Charon should learn to take a good sexual history. A skillful introduction can help assure the patient that the physician is comfortable discussing sexual topics, that all information will be held in confidence within the constraints of the law, and that the information will help the physician to provide better care. A more effective sexual history might have resulted in faster diagnosis, more appropriate treatment, and better protection against spread of the infection.

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Clinical Case

Too Much Information?

Commentaries by Christopher Kodama, MD, and by Kathryn M. Conniff and Ligia Peralta, MD

Andy Hanson was admitted to Shady Grove Hospital with a pneumonia that progressed to an empyema. He was assigned to the teaching service with Dr David Lee attending, along with a second-year resident, Dr Mary Weiss. Dr Weiss did an initial interview and recorded her history and physical in the chart. She presented her findings to Dr Lee and they agreed upon a plan to have the empyema drained and antibiotics started.

The following day, Dr Jan Krause, a physician colleague of Dr Lee's approached him to express some concerns. She had been on call the night before and was asked a question about Andy's care. Upon reviewing his chart she noted the sexual history that was documented by Dr Weiss. Dr Weiss' full sexual history included documentation that Andy was a homosexual, became sexually active about a year earlier at age 15, and "mostly" used condoms. The history also noted that Andy had several sexual partners in the last year and documented his typical sexual practices. Dr Krause told Dr Lee that she felt that the history was too graphic and was inappropriate for inclusion in the chart. She explained that she felt obligated to refer this case to the hospital ethics board and was going to do so.

Dr Lee reviewed the chart. He and Dr Weiss had discussed the patient's sexual history, and, based on his risk factors and his disease presentation, they had already decided to order additional testing, including an HIV test.

A few days later Andy was recovering well after drainage of his empyema. He was feeling better and was excited to go home soon. In checking his morning lab results, Dr Weiss noted that Andy's HIV test had come back positive. Dr Weiss and Dr Lee counseled Andy about this result, arranged for the HIV clinic coordinator to see him, and began to plan his outpatient follow-up. The following week Andy was discharged. Because of the complaint lodged by Dr Krause in regard to the medical records, Drs Lee and Weiss were asked to sit before the hospital ethics board.

Commentary 1

by Christopher Kodama, MD

In this case involving Andy Hanson, Dr Krause takes issue with the level of detail of the sociosexual history rather than the possible implications of the documentation of sexual orientation and behaviors in the medical record. The case raises 2 issues: first, how thorough a sexual history should be taken? Second, if patient information is

obtained verbally, how much should be recorded verbatim in the medical record and how much can be paraphrased, eg, “The patient engages in sexual activities that place him at greater risk for acquiring a sexually transmitted disease (STD).” Paraphrasing raises a related question; does paraphrased information maintain the integrity of the narrative from a legal perspective? Before discussing these questions, we must first understand the definition of a medical record.

What is a health record?

The medical record, or the Legal Health Record (LHR) as it is referred to by the American Health Information Management Association, serves both the medical and the legal functions of documenting a narrative of a patient’s health history. It is a protected forum for communicating clinical care plans, and “it documents and substantiates the patient’s clinical care and serves as a key source of data for outcomes research and public health purposes” [1]. Many additional definitions exist and are constantly being refined, particularly with the advent of electronic medical records (EMR), but the essence remains the same: the LHR helps caregivers organize thoughts about a patient’s health.

How thorough a sexual history should be taken?

In taking an accurate sexual history, medical students are taught to know the difference between open-ended versus closed-ended questions. However, as many who work with adolescents can attest, open-ended questions are often met with limited monosyllabic answers which are both frustrating to the clinician and not particularly helpful in identifying potential medical issues that warrant further investigation. Most have heard the anecdote of the adolescent who, when asked whether or not she is sexually active, responds “No.” When her pregnancy test returns positive and the patient is confronted about her response, she answers that she is essentially “passive” during intercourse. Clearly this disconnect could be avoided by asking question in a more direct manner: “Do you engage in vaginal intercourse?”

One can be accurate without being pornographic in obtaining a detailed sexual history. HIV switchboard operators are trained to ask about specific practices to help the caller determine his or her level of risk and avoid misunderstandings based on cultural, age, sexual orientation or gender variation. The American Academy of Pediatrics implies the need for detailed questioning as described in a 2004 clinical report on nonheterosexual adolescents: “Discuss the risks associated with anal intercourse for those who choose to engage in this behavior, and teach them ways to decrease risk” [2].

The caveat to this argument for historical accuracy is that this portion of the history must be approached with the same level of sensitivity and insight that the rest of the adolescent history receives to avoid alienation of the patient and false negative responses to questions. In her article “The Proactive Sexual Health History,” Margaret Nusbaum outlines how important it is for clinicians to become comfortable with addressing an area of health that is often a source of potential anxiety for patients though no less important to them [3]. Regardless of whether this discussion takes

place in an inpatient or outpatient setting, it is an opportunity for potential treatment and prevention counseling.

How should the sexual history be documented in the LHR?

There is no legal mandate that states that verbal history must be transcribed verbatim so long as the paraphrase maintains the essence of the communication. However, if the LHR is a place for clinicians to communicate thought processes clearly, providing detail in the LHR about sexual practices may be relevant. For example, documenting that a patient admits to oral sex (ie, performing on a partner) but not anal sex places that patient in a different risk category for contracting HIV, but is an increased risk factor for gonococcal pharyngitis. This level of documentation can be useful for other clinicians as well as for the billing/coding department in terms of substantiating related studies or management strategies. It also allows more specific counseling to be given to the patient about possible repercussions of a specific sex act.

One could also paraphrase this information in more general terms, but at the expense of truly knowing this patient's risk factors. This omission might also subject the patient to redundant questioning at a later time about sensitive issues or dilute a counseling process that is based on unfounded assumptions about the patient's risk factors.

Furthermore, in the age of the EMR, research and data gathering may be facilitated by the use of catchphrases or keywords to identify patients for inclusion in a study. For example, a health department study on specific STDs may seek out particular behaviors that are relevant to the goals of the study.

Given the above discussion, there is no significant difference whether information is documented in the inpatient or outpatient record, as they are equally important threads of a patient's health narrative.

Counseling the Resident

When speaking to the resident who took the adolescent's sexual history, it may be prudent to support the use of clinical and objective terms, rather than slang, in the LHR. Another point worth reviewing is that one can ask the patient directly what information he would feel comfortable having documented in the medical record. This obviates the need for the explanation of basic confidentiality and HIPAA guidelines that otherwise should occur at the beginning of any adolescent interview [4]. Last, it may be protective for the clinician to have a nursing chaperone present so that information discussed, although confidential, is witnessed in case a question is raised about whether the history was obtained in an appropriate manner (though what is considered appropriate or inappropriate may be highly subjective, as highlighted by this case).

Conclusion

In the context of this specific case, it seems that the physician reported this case to the review board because of concerns about the possibly inappropriate graphic nature of the documentation. If the above recommendations about relevance and appropriate

(non-slang) documentation have been met then it would suggest that the complaint was based more on individual style and discomfort regarding the subject matter. If that was the case, and the report does not raise ethical concerns about confidentiality or disclosure, then there is not a role for the ethics board.

Squeamishness and embarrassment on the part of the physician about discussing the sexual history may be understandable given the dissimilarity of his or her background and that of the patient, but the embarrassment must be overcome in the best interest of the patient. Ultimately, it is the responsibility of the physician to use common sense in determining if the information obtained and the way it is documented is relevant to the patient's care and outcomes.

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Commentary 2

by Kathryn M. Conniff and Ligia Peralta, MD

Dr Weiss should be commended for making Andy feel comfortable enough to disclose his sexual history. It is difficult for many clinicians to elicit information about sexual practices and risk behaviors from an adolescent—straight or gay. It is the clinician's responsibility, however, to gather detailed information during the interview process in order to identify risk behaviors and to ensure that a proper diagnosis is made and that the patient receives the best possible care and counseling. Had Dr Weiss not completed a full sexual history, the presenting problem alone may not have led to the diagnosis of human immunodeficiency virus (HIV). This would have been a disservice not only to Andy but also to his past, present, and future sexual partners.

A Comprehensive Sexual History

A comprehensive sexual history is a vital part of the medical evaluation of all adolescents. The clinician should ask questions in a nonjudgmental manner, beginning with less personal questions and progressing to more sensitive areas [1]. In addition to Dr Weiss' questions (sexual orientation, age of onset of sexual intercourse, condom use, number of sexual partners, and typical sexual practices), a complete sexual risk history should include age of partner(s); sexually transmitted infection (STI) history including symptoms, treatment, and prevention measures; partner's risk factors for STIs; drug or alcohol use before or during sex; history of sex in exchange for food,

money, drugs, or a place to sleep or live; and history of sexual abuse or negative sexual experiences [2]. These details are necessary to assess the patient's risk of HIV infection, and their relevance has been corroborated by multiple studies, which showed that:

1. Adolescents who have unprotected intercourse, especially those who begin at younger ages, with multiple and older partners, or in geographic areas with a high HIV seroprevalence are at greater risk for HIV infection [3].
2. STIs are highly correlated with and predictive of HIV infection, leading some researchers to use STIs as a surrogate marker for behaviors associated with HIV infection. Certain STIs may also increase susceptibility to HIV infection, particularly those associated with genital ulcers, which provide easy access to HIV entry through the compromised skin barrier. The increased incidence of syphilis and chancroid parallel the rise in HIV rates [3].
3. Certain types of sexual practices are associated with a greater risk of HIV transmission. For example, receptive anal intercourse may be a more efficient means of transmission than vaginal intercourse, which in turn may be more efficient than oral intercourse [3].
4. For sexually active persons, condoms are the only form of protection against HIV infection, yet a national survey of 17-to-19-year-old males revealed that only 3 out of 5 in this age group had used them the last time they had intercourse. Condom use was lowest among males who reported 5 or more sexual partners or intravenous drug use [4]. Another survey conducted among middle-class urban adolescents showed that only 8 percent of males used condoms every time they had intercourse [5]. When used properly, latex condoms are an effective barrier against STIs, so adolescents lower their risk for HIV infection if they consistently use condoms during intercourse [3].
5. Alcohol and drug use impairs judgment and therefore further increases the probability of unprotected sex [6]. Adolescents who use alcohol before intercourse are 2.8 times less likely to use condoms, while those who use marijuana before intercourse are 1.9 times less likely to [7].

Sexual Risk Assessment

The primary purposes of the sexual risk assessment are to identify and triage high-risk adolescent youth into appropriate services and to tailor interventions for prevention and risk reduction to the needs of a particular adolescent [3]. All information obtained during the sexual history should be documented in the chart regardless of the setting (inpatient and outpatient) so that any future clinicians are fully aware of the patient's risk-related behaviors and can screen, treat, and counsel him or her accordingly.

Special Considerations for Gay and MSM Adolescents

Gathering a detailed sexual history from a male adolescent who has unprotected sex with other males (MSM) is especially crucial because these partners are at particularly high risk for contracting HIV [5]. MSMs ages 20 and older represent the largest HIV transmission category [6]. In 2003, the CDC estimated that 63 percent of newly diagnosed HIV cases in the US were among MSMs [8]. More recent data from 5 of the 17 cities participating in the National HIV Behavioral Surveillance (NHBS) system from July 2004 to April 2005 indicated that 25 percent of the MSMs surveyed were infected with HIV. Forty-eight percent of those who tested positive were unaware of their infection. The proportion of unrecognized HIV infection was highest among MSMs under 30 years of age [9].

The stigma associated with homosexuality often drives gay or MSM adolescents to explore their sexuality in “secretive and sometimes unsafe ways” [5]. Although safe-sex messages aimed at the gay community are ubiquitous, MSM adolescents often do not have access to or ignore the messages because they do not identify themselves as gay [5]. For example, in a study of 72 MSMs between the ages of 16 and 25, 69 percent self-identified as gay, while the remainder self-identified as bisexual (14 percent), gay or bisexual (6 percent), ambivalent or exploring (6 percent), transgendered (3 percent), or heterosexual (1 percent). MSMs who did not self-identify as gay reported a lack of acceptance by the gay community. Furthermore, many MSMs of color did not consider themselves gay if their MSM activity was limited to receptive oral sex [10]. The discrepancy between sexual orientation and behavior can lead to false assumptions about risk behavior and misguided counseling, so it is imperative that clinicians distinguish between sexual identity and activity [6].

Consent and Confidentiality

Although this case does not make specific reference to HIV counseling, testing, and referral, these topics should be addressed. Clinicians should counsel *all* sexually active adolescents about the significance of HIV testing and offer voluntary testing with informed consent (most states permit minors to give their own consent for STD testing and treatment) [11]. The federal Health Insurance Portability and Accountability Act (HIPAA) protects patient information from inappropriate disclosure by health care clinicians, insurers, and certain government programs (eg, Medicaid) [12]. Many states have additional laws that limit parents’ rights to access their children’s medical information, but the specifics of such regulations vary from state to state [11]. Clinicians should become familiar with HIPAA and the laws of their particular state, as it is their responsibility to ensure that adolescents are fully informed about disclosure requirements. This is vital because the fear of inappropriate disclosure causes many adolescents to avoid or delay needed care [6]. For gay youth, this anxiety is compounded by the possibility that they will face homophobic discrimination, loss of close personal relationships, or even banishment from home, upon disclosure of their sexual orientation [6].

Pretest Counseling

Before adolescents sign the consent form, clinicians should present to them the advantages and disadvantages of testing and available testing options in “simple,

culturally and developmentally appropriate language” [6]. Adolescents should be encouraged to involve a supportive adult in the testing process. In addition to discussing the test itself, the pretest counseling session gives clinicians the opportunity to talk to adolescents about sexuality, to identify high-risk behaviors, and to devise a personalized risk reduction plan [6, 13].

Post-Test Counseling

Clinicians should provide results in a straightforward manner, allow plenty of time for the adolescent to respond, validate the response, and then ensure that the adolescent understands the meaning of the results. Other important aspects of post-test counseling include helping adolescents identify support systems and offering assistance in notifying partners and parents. Counselors should emphasize risk reduction behaviors and develop short- and long-term plans to address adolescents’ emotional and medical needs such as mental health or drug rehabilitation referrals or both. In addition, clinicians may provide services such as a contact list with phone numbers for emergency mental health services, a 24-hour crisis hotline, and follow-up appointments [6].

Conclusion

The sexual risk history is a relevant and indispensable part of the medical interview that aids the clinician in his or her understanding of the patient’s risk for HIV infection. The clinician should err on the side of documenting more detail, not less, to aid other clinicians in the continued care and counseling of the patient. Protective measures such as HIPAA ensure patient confidentiality, so the information Dr Weiss documented in Andy’s chart does not present any ethical concerns. Thus, Dr Krause’s referral of Drs Weiss and Lee to the hospital ethics board was inappropriate.

Dr Weiss’s “graphic” sexual history was merited because it led to the discovery that Andy was infected with HIV, a diagnosis that not only shed light on the cause of his current problem but also opened up an opportunity for a public health intervention. As a result of Dr Weiss’s history and diagnosis, Andy may be linked to appropriate continuous care, allowing him to live a healthier life and take measures to prevent further transmission of the virus. The hospital ethics board should therefore dismiss Dr Krause’s complaint. Instead, the board might recommend implementing a workshop aimed at improving clinician’s competency in approaching and managing sexual minorities and the importance of eliciting a comprehensive sexual history from all patients.

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Clinical Case

“Universal” Precautions

Commentary by Leslie E. Wolf, JD, MPH

Alexi Tournoff came into the City Hospital Emergency Room for treatment of fever and lymphadenitis. Frank Spitz, a third-year medical student, took the history and physical and discussed the case with the attending physician, Dr Ina Anderson. They decided that Alexi should be admitted for intravenous antibiotics.

Alexi’s nurse, Susan White, chatted with him as she placed his IV line. Because of his youthful appearance and his having checked “single” marital status on the intake sheet, Susan asked him, “So, do you have a girlfriend that you need to get in touch with about being admitted?” Alexi informed Susan that, actually, he’d had a boyfriend for 5 years and that he had already told him he was going to the hospital.

Susan then left the room and told her co-worker, Anna, about the exchange. “You better use barrier precautions with him. He may have HIV,” Anna said.

“Who has HIV?” asked the charge nurse, overhearing their conversation.

“The guy in room 3,” replied Anna. “He says he’s gay and he has lymphadenitis.”

“Well, we don’t know for sure,” Susan explained.

“Better wear protection when you go in there,” instructed Anna.

Susan then noted that the IV in Alexi’s room was beeping. She put on a yellow cover gown and mask before entering the room. In the room, she double-gloved as Alexi watched her curiously. After fixing the IV she left the room and called the ward that was accepting Alexi. She informed the accepting nurse that the patient was gay and HIV precautions were in order. She said that she wore a gown and mask and double-gloved “because you never know.” The ward nurses discussed the situation among themselves and decided to follow Susan’s recommendations. Contact and respiratory precautions were posted for all people entering the room.

The following morning on the ward, Frank, the medical student, again visited Alexi. The precautions sign puzzled Frank. He checked the chart and saw no order for precautions, so he assumed it was a mistake. He entered the room without wearing any barriers and conducted his physical exam. Dr Anderson then joined Frank at the bedside; Dr Anderson was not wearing any protective garb either.

Dr Anderson explained that Alexi's EBV titers had come back very high, suggesting that Epstein-Barr virus was the cause of his current infection. Alexi was happy to hear that nothing more serious than mono was going on. "I thought for sure something awful was happening! All of the nurses were coming in here in gowns, masks, and multiple pairs of gloves. They seemed really stand-offish, like they didn't want to touch me. When I asked why, they wouldn't tell me. I was wondering if I was dying," he explained.

Dr Anderson shrugged her shoulders and said she had no explanation for the nurses' behavior. Dr Anderson and Frank then left the room. Frank asked Dr Anderson about the nurses' behavior and the precautions sign on the patient's door. "Oh, you know nurses. They sometimes overreact to patients that they think may have HIV," she said dismissively.

"But the patient was tested last month and was negative. His primary care physician faxed his labs over yesterday," Frank persisted.

"You know, sometimes it just doesn't make a difference. People around here overreact about gay patients. Not much we can do about it," Dr Anderson replied.

"But you heard the patient. It really bothered him to be treated like a leper. I don't understand. Isn't there someone we can talk to about this?" Frank said in frustration.

"Well, you are quite the idealistic student aren't you? Tell you what, do whatever you want. Let me know if you find out anything," Dr Anderson said, laughing.

Commentary

This case raises several ethical issues that physicians commonly face. How does one balance caring for a patient and protecting oneself from harm? Can patient information that may be required to protect health care providers from harm be shared with others? What information must be disclosed to patients? What should you do when you observe unprofessional behavior?

Protecting Oneself from Harm

Clinicians understandably may have concerns about how to protect themselves from infection. Their responsibilities for patient care may put them at risk. While they have an ethical obligation to act in the best interests of patients under their care, they need not disregard their own safety and well-being [1]. It is appropriate to take precautions against infection, but those precautions must be reasonable under the circumstances.

In this case, some of the precautions that the nurses implemented were not warranted, given how human immunodeficiency virus (HIV) is transmitted. HIV is not spread through casual contact but requires exchange of bodily fluids [2]. HIV is not spread through the air, so respiratory precautions were unnecessary. On the other hand, a needlestick can transmit HIV, so wearing gloves when (re)inserting an IV is reasonable. Even if the nurses believed *all* the precautions they instituted were

necessary to protect them from infection, that does not make their actions reasonable. In *Bragdon v Abbott*, the US Supreme Court considered what evidence of risk the Americans with Disabilities Act requires in order to permit restrictions on care of an HIV-infected individual. In that case, a dentist had agreed to treat an HIV-infected patient only in a hospital, based on his belief that hospitals had safety measures not available in his office that would reduce the risk of HIV infection. The Court concluded that the assessment of risk must be based on “objective, scientific information,” not the dentist’s professional (and erroneous) judgment [3].

In this case, the actual risk of HIV infection was low. The nurse made an assumption that the patient might be HIV-infected based on his sexual orientation. However, his HIV risk depends on his behaviors, not on his sexual orientation. Indeed, if the patient and his boyfriend of 5 years have had a mutually monogamous sexual relationship, the likelihood that the patient is HIV-infected could be quite low. His medical records confirm that his recent HIV test was negative.

Being cautious is not often a problem. However, in this case, the nurses’ actions had a negative effect on the patient. Because the nurses approached him fully gowned, masked, and gloved and were reluctant to touch him, the patient became anxious and concluded that he was more seriously ill than he was. This problem might have been avoided had the nurses told the patient the reasons for implementing precautionary measures. Having to explain their actions might also have caused the nurses to think critically about which precautions were actually necessary.

Access to Confidential Information

This case also raises the question of who should have access to confidential patient information. Confidentiality is essential to good patient care; it enables patients to share personal information relevant to their care. Confidentiality has been particularly important in the context of HIV because of the stigma associated with HIV/AIDS and the potential for discrimination and other social harms. As a result, HIV/AIDS information receives even greater protection than other medical information [4]. However, health care providers may need access to confidential patient information in order to protect themselves. While information about a patient’s HIV infection may be shared within the medical team, such disclosures should be limited to those who directly care for the patient and therefore have a need to know. The case suggests that the charge nurse overheard the patient’s nurse’s comments about the possibility of HIV infection. While the charge nurse may need to know this information because of her position, the way that she learned about it serves as a reminder of the risk of inadvertent disclosure of confidential patient information. Some hospitals have implemented programs, including posters and cards, to remind staff to avoid confidential discussions in public places.

Alternatives for the Physician

The attending physician could have taken several steps to ameliorate the situation. First, she could have addressed the situation with the patient, who was clearly upset by how the nurses had treated him. Dr Anderson could have responded to the patient’s concerns without endorsing the nurses’ behavior. For example, she could have

apologized that the precautions caused the patient anxiety and explained that the nurses were taking steps to protect themselves from infection. Second, she could have used the case as an opportunity to educate the nurses and other staff members. It is possible that the nurses have misunderstandings about how HIV is transmitted. Such education may take place informally, in one-on-one discussions, or through formal staff-wide trainings. The attending physician need not take on the training responsibility herself if she brings the issue to the attention of department managers.

Role of the Medical Student

As a medical student, Frank may feel powerless to remedy the situation, but there are some steps that he can take; in fact, he has already taken the first step by mentioning the incident to his attending physician. It is important for medical students to ask questions when they are confronted with circumstances that make them uncomfortable. In some cases, medical students may misunderstand the situation because they do not fully understand the medical circumstances. For example, they may incorrectly view an adverse event from an intervention as a “mistake.” Communicating with attending physicians can clear up such misunderstandings. In this case, the attending validated Frank’s concerns but was unwilling to act. Frank may be reluctant to discuss this situation with other physicians out of concern that the attending may misunderstand his efforts and retaliate against him. One appropriate avenue for Frank is discussion with the clerkship director. The clerkship director may be able to facilitate further discussions with the attending, if desired, or use the case anonymously in teaching.

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Journal Discussion

It's Getting Better All the Time

by Abraham P. Schwab, PhD

Golden MR, Manhart LE. Innovative approaches to the prevention and control of bacterial sexually transmitted infections. *Infect Dis Clin North Am.* 2005;12:513-540.

Though it would be a stretch to say the silver bullet for bacterial sexually transmitted infections is close at hand, Golden and Manhart show us some encouraging responses produced by recent research.

Changing Behavior

Interventions to change behaviors have provided a number of positive responses. Golden and Manhart note that these "behavioral interventions," whether one-on-one or in groups, induce changes in self-reported risk-taking behavior. They do not rule out that shame (at not changing behavior) could be a factor in the 30 percent decrease in risky behavior self-reported within some groups. Golden and Manhart suggest that inadequate equipment and limited resources play a dominant role in the failure to translate this research into practice. The conclusions of this research lie inert in the pages of journals and data banks. They also suggest that when behavioral interventions are primed for use, they should be used outside of traditional settings such as sexually transmitted disease (STD) clinics.

Non-traditional Testing Sites

Pursuing testing in unusual locations is also recommended by Golden and Manhart. A relatively new test in the diagnosis of infectious disease, the nucleic acid amplification test (NAATs or NAT in acronymic form) allows for much more accurate and less invasive testing. NAATs identify the targeted RNA or DNA and not, as previous assays did, the antibodies caused by the infectious disease. The less invasive means of testing (a urine sample or vaginal swab) allows NAATs to be offered outside of STD clinics. Golden and Manhart list some of these locales but suggest that targeted screening (and not broad population screening) will likely be the most cost-effective. Some groups and subgroups are not as likely to acquire these infectious diseases as others. Here Golden and Manhart leave the reader wanting more. If we are to limit testing, what would be a likely protocol for site selection? If schools and juvenile detention facilities are targets, do we start broader-based testing after a single positive test? A few? A percentage? Moreover, they note that political challenges abound. (You can just hear the parents saying, "Well, my daughter doesn't have sex, so why should she be subject to these tests?") Like the rest of us, they have no solution to this challenge.

Rescreening

Making up for a lack of clarity with succinctness, Golden and Manhart announce, “People who have STIs get STIs” [1]. We are left to presume that they simply forgot the word “had” between “have” and “STIs.” Their point, which they articulate throughout the section, is that rescreening will be a cornerstone public health effort to limit the spread of STIs—sexually transmitted infections. They note with resignation that, although rescreening is merited on the basis of substantial evidence that persons who have STIs are at high risk for infection in the months following their treatment, mechanisms to ensure retesting have not been established. Furthermore, how to promote retesting outside of STD clinics has not been studied [2]. This, of course, may be a problem of access and insurance that Golden and Manhart fail to mention.

Peer Referral and Expedited Partner Therapy

Golden and Manhart identify another area of mixed success. Cluster tracing (or cluster case finding) operates on the assumption that people who have STIs know people who have STIs. It’s a bacterial or viral birds-of-a-feather story. “Suspects” are friends or acquaintances of the positive case, including those with nonsexual contact. Peer referral is an important application of this principle that has included a “carrot” for referrals (though Manhart and Golden do not tell us what these incentives usually are). The new hot topic in STI treatment is expedited partner therapy (EPT). In short, “EPT is a global term for approaches to treating the sex partners of persons with STIs that bypass the traditional requirement that all partners receive a complete medical evaluation before therapy” [3]. According to Golden and Manhart, the less-than-ideal partner treatment rate (50 percent) alongside the existing haphazard partner notification system suggests that public health can be better served by these approaches. The most common example of EPT is patient-delivered partner therapy (PDPT). In most cases this is a low-risk, high-benefit treatment plan (a cited exception is women with trichomonas), but serious medical and nonmedical questions linger. As promising as recent research has been, Golden and Manhart point out that the results are not definitive.

The Centers for Disease Control (with public expressions of support from the AMA) is currently examining the usefulness of PDPT and reviewing evidence regarding EPT efficacy in general, including the practices already in use. One concern, noted by the AMA in Report 9 of the Council on Scientific Affairs, is the legal standing of PDPT [4]. Some states currently do not allow physicians to prescribe or give prescriptions without seeing a patient. Moreover, individuals could game the system in a number of ways, including getting prescriptions at a discount (via insurance) to sell to others at cost. Finally, an important medical question will need to be answered on a therapy-by-therapy basis: what risks are associated with unnecessary treatment (eg, treating the partner who doesn’t have the STI that the patient has). Official sanction of PDPT will likely be withheld until these issues are settled.

Internet Use

Golden and Manhart include a brief analysis of mass treatment and selective mass treatment of STIs. They conclude that only sustained selective mass treatments have any real chance of impact, though the degree of impact is unknown.

There is also encouraging news about the use of the Internet for interventions. Informational links that piggyback on Internet sex sites are accessed often, and chat rooms have been established with some success. There is no research here, but the Internet seems to hold promise for educational material dissemination and partner notification as well as possible counseling.

Next Steps

Golden and Manhart conclude, and it's hard to argue on this point, that future research should focus "more on developing and testing sustainable, cost-effective interventions that focus on those at greatest risk and that can be scaled-up within the existing public health infrastructure" [5]. The need for this focus is indicated, primarily, by the paucity of funding for a more drastic restructuring of the public health infrastructure for screening and treatment of STIs. In terms of medical and administrative factors, I think they're right, but what they don't get at is the critique from proponents of abstinence and monogamy that would suggest we should be telling these people not to have nonmonogamous sex. Indeed, it would have been worthwhile to cite some studies to show that that approach doesn't work.

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Medical Education

Why Do We Take a Sexual History?

by Ponrat Pakpreo, MD

During my training in adolescent medicine, one of my preceptors posed this question to me, “If you ask *that* question, what will you do with the answer?” Taking a patient’s sexual history is a situation in which we should be mindful of why each question is being asked and what action will follow from the answer.

Taking a sexual history from adults and adolescents is a necessary first step toward providing contraceptive, reproductive, and sexually transmitted disease (STD) counseling. A sexual history screens for high-risk sexual behaviors, may identify sexual problems, and is an opportunity to provide information and support to patients. Statistics illustrate that having sex is not a rare event for adolescent and young adult patients. In a national survey of high school students, nearly half (46.7 percent) reported having had sexual intercourse [1]. Between 800 000 to 900 000 adolescent females under the age of 19 become pregnant every year [2]. Sexually transmitted diseases are also a concern. Chlamydia and gonorrhea rates are highest among females aged 15-19 years old and males 20-24 years old [3,4].

Who should we screen?

Many high-risk-taking behaviors begin in adolescence. In fact, 7.4 percent of teens have had sex before the age of 13 years [1]. Despite this, researchers found that “clinicians were less likely to screen younger adolescents than older adolescents” [5].

At the other end of the life cycle, some health care professionals assume that older adults are sexually inactive and fail to assess their sexual health. Older adults are at risk for sexually transmitted infections and may be less forthcoming about sexual problems [3,4,6-9]. In a study of sexual activity among older adults, 31 percent of men and 43 percent of women reported sexual dysfunction [9]. In the Massachusetts Male Aging study, 52 percent of men 40 to 70 years old experienced erectile dysfunction [10].

Unfortunately, studies show low rates of sexual health assessment by physicians and other health care professionals [11]. Time constraints, underestimation of patient risk, and embarrassment prevent some clinicians from conducting this assessment [11-15]. Others may not believe that a sexual history is medically relevant to the visit, while still others are unfamiliar with some sexual practices and avoid the topic entirely [14].

In the case of adolescent patients, many clinicians fear that teens will disclose sexual activity, initiating a cascade of questions to assess pregnancy and STD risk. This may lengthen the visit and raises issues of confidentiality, parental involvement and

knowledge, and changing risk-taking behaviors. With older patients who may be their parents' or grandparents' age, some young physicians are uncomfortable asking questions about sexual dysfunction or satisfaction [14].

Do patients want to be asked about sex?

Patients who do not discuss their sexual health with clinicians often wish they had and that the discussion had been part of a routine exam [16,17]. Most adolescents believe it is important to discuss sexual intercourse, contraception, pregnancy, unwanted sexual activity, and sexually transmitted diseases [17].

Are physicians trained to do a thorough sexual history?

Many graduating clinicians do not feel adequately prepared to evaluate sexual health problems [17]. Older physicians report less STD assessment training during medical school and residency than do younger physicians. However, training in sexual history assessment may be increasing in medical school education [18,19], and students who have had sexuality/sexual health instruction report greater confidence in addressing this topic with patients [20.] Physicians who conduct sexual histories are also more likely to test patients for STDs [21,22].

When should a sexual history be taken?

Often a sexual history is obtained when a patient presents with a specific symptom such as vaginal discharge, but opportunities aside from problem-focused visits exist and should be acted upon. Early adolescents and older adults should receive sexual health screenings at their check-ups, well visits, or preventive health visits. A sexual history may be obtained during the review of systems or during the personal and social history. The Guidelines for Adolescent Preventive Services (GAPS) screening tool, available online, assesses several risk factors including sexual activity and can be given to adolescent patients before the physician enters the room [23].

Elements in a Sexual History

The following is a list of elements that are essential to taking a good sexual history. Many other sources exist for detailed examples of sexual risk assessment questions [12,24-28].

1. Confidentiality: Establish a safe and comfortable environment to discuss personal health issues. At the beginning of the visit, emphasize patient confidentiality and its limits [29].
2. Patient concerns: Ask open-ended questions. This may help begin the discussion, but you also may have to ask specifically about sexual problems or concerns. Many patients want to ask questions but won't unless given the opportunity.
3. Sexual orientation and preferences: It is important not to assume heterosexuality when obtaining a sexual history [30]. Many primary care physicians learn about sexual orientation when the patient spontaneously

discloses [14]. This question can be prefaced by stating “I ask this question of all of my patients: are you interested in men, women, or both?”

4. Age of sexarche: Younger adolescents who are in relationships with older partners know less about pregnancy prevention and STDs, and are at greater risk of being coerced into sexual activity and becoming pregnant [31-33].
5. Types of sexual practice (oral, anal, vaginal): Elicit information about sexual behavior and types of sexual practice in the assessment for STD risk and presentation (eg, vaginitis, pharyngitis, proctitis).
6. Last sexual intercourse: The date of the most recent sexual encounter is important for pregnancy and contraceptive counseling as well as for STD treatment and prevention.
7. Sexual partner assessment: The number of lifetime partners, number of partners in last 6 months, nature of the relationship (eg, serial monogamy versus one-time events, ability to negotiate use of condoms or birth control devices), and intimate partner violence screening are part of STD risk assessment.
8. Pregnancy prevention or desires: It is important to understand the patient’s desires regarding pregnancy, so that counseling is consistent with his or her goals, and information and advice is appropriate.
9. History of prior pregnancies and outcomes: Again, this is helpful in contraceptive and reproductive counseling to identify risk and needs.
10. STD prevention practices: Inquire about condom usage (eg, consistency, correct use, access), regular STD testing, and reduction in number of partners.
11. STD symptoms: Recognize that patients may be asymptomatic, and use the assessment to provide education regarding STDs.
12. History of prior STDs: Eliciting this history is an opportunity to discuss how to prevent future STDs, potential infertility and to assess STD risk.
13. Problems related to sexual intercourse.
14. History of sexual abuse.

Not every question need be asked at the initial visit; some may be reserved for subsequent visits. If patients realize that a sexual history is part of a routine exam, they may be more comfortable raising questions or concerns in the future. Also, if patients see their clinicians sensitively and comfortably asking these questions, they may view them as a resource for sexual health information.

Medical Education and the Sexual History

Learning how to take a sexual history should be part of medical education. It can be integrated into the curriculum in several ways:

1. Students should have opportunities to take a sexual history in inpatient and outpatient settings.
2. Faculty should demonstrate how to take a sexual history.
3. As medical schools incorporate sexual history taking into curricula, an evaluation of students' skills, comfort with, and frequency of taking sexual histories should be made as well as an evaluation by patients about how the sexual history was obtained.
4. For those students and physicians who are uncomfortable obtaining a sexual history, increased experience in asking sensitive questions about sexual health practices and beliefs may decrease anxiety in asking these questions.

Understanding our own feelings about diversity in sexuality and sexual health across the lifespan will help us communicate with our patients about these issues.

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Clinical Pearl

Management of Needlestick Injuries in the Health Care Setting

by Josiah Penalver

Needlesticks are a common occurrence in the health care profession. It is estimated that 600 000 to 800 000 needlestick injuries occur per year in the United States [1]. Of these, many, if not most, go unreported [2]. In response to the risk of exposure, institutions have focused on primary prevention as a means of reducing the incidence of needlesticks and thereby decreasing the number of bloodborne pathogen transmissions. Needlestick injuries still occur, however, and it is important that individuals in the health care field become well informed about the exposure risks and educated regarding the appropriate response.

What are the primary pathogens transmitted?

1. *Human Immunodeficiency Virus (HIV)*: The average risk of seroconversion after a needlestick injury from a confirmed HIV source is approximately 0.3 percent without post-exposure therapy [1]. Certain factors contribute to elevated risk [3]:

- Increased depth of the puncture wound
- Visible blood on the needle
- Needle used in the vein or artery of the patient
- Patient with terminal HIV as source of the fluid

2. *Hepatitis B Virus (HBV)*: The risk of acquiring hepatitis secondary to HBV percutaneous exposure varies based on the serological status of the patient. In the worst case scenario, if the patient has active replication of the virus (indicated by HBeAg-positive blood [4]) then the risk of developing clinical hepatitis is as high as 31 percent [3]. When the patient has HBsAg-positive blood but is HBeAg-negative (indicating a less infective state), the risk is significantly lower, about 1 to 6 percent [3].

3. *Hepatitis C Virus (HCV)*: The risk of HCV seroconversion after a needlestick injury from a patient infected with HCV is approximately 1.8 percent [1]. Unfortunately, there is little evidence to support postexposure treatment as a means to decrease the risk of infection.

Role of Vaccination

Of these 3 infections, vaccination is available only for HBV. In the 1970s, the risk of acquiring HBV was 10 times greater in health care workers than in the general population [3]. This risk has significantly declined, due in part to an aggressive vaccination campaign geared toward hospital staff [3].

Facts about the vaccine [5]:

- A series of 3 shots made from HBsAg is administered.
- Vaccination response can be confirmed by assessing for anti-HBs 2-3 months after completion of the series.
- Efficacy is approximately 95 percent in healthy adults.
- Protection lasts at least 10 years after vaccination, but may last much longer [6].
- Currently, no booster is recommended.

What protocol should be followed after any needlestick?

First, *do not panic*. Protocols are in place to minimize the risk of infection after exposure. Second, do not ignore the exposure. Acting within outlined timeframes can lead to a significant decrease in the transmission rate of certain infections. The following measures also should be taken [1]:

- The site should be immediately washed with soap and water.
- The incident should be reported and an exposure report sheet completed.
- The exposure should be assessed (type of fluid, type of needle, amount of blood on the needle, etc).
- The exposure source should be evaluated:
 - a. HIV, HBV, and HCV status of the patient;
 - b. Consent and testing of the patient for these diseases if the status is unknown;
 - c. Likelihood of infection based on the community served by the hospital if the patient is not available to be tested.
- Appropriate management of any positive exposure is necessary

Virus-specific Post-exposure Management

1. *HIV*: Use of post-exposure prophylaxis can help to reduce the risk of contracting HIV. Maximal benefit can be obtained by initiating treatment within hours of exposure. Guidelines include the following [1]:

- Start post-exposure prophylaxis as soon as possible.
- Reevaluate the exposed individual within 72 hours, particularly focusing on new information regarding the source and the exposure.
- If the source is determined to be HIV-negative, post-exposure prophylaxis can be discontinued.
- If the source is determined to be HIV-positive, continue treatment for 4 weeks if tolerated.
- All workers exposed to HIV should undergo HIV antibody testing at 6 weeks, 12 weeks, and 6 months.

A few additional considerations regarding HIV exposure management:

There is the possibility of toxicity with antiretrovirals, so use should be restricted to exposures in which reasonable risk of transmission is present.

- 2-drug therapy (with 2 nucleoside analogues) is recommended, although 3-drug therapy may be warranted under certain circumstances (ie, a source with a high viral load or known drug resistance).
- One should inform the treating physician about pregnancy status and current medications because these can influence the selection of a treatment regimen.
2. *HBV*: The treatment after exposure varies based on the vaccination status of the exposed individual and the HBV status of the patient [1]:
 - Regardless of the status of the patient, if an individual suffers a needlestick and is unvaccinated, the vaccination series should be initiated.
 - If an individual has been vaccinated and has a documented response to the vaccine, then no treatment is required after an exposure.
 - If the vaccination status of the exposed individual is unknown, he or she should be tested for anti-HBs before deciding on treatment.
- 3. *HCV*: No treatment has been shown to prevent infection for workers exposed to HCV. Recommendations center on following workers after the injury and monitoring for HCV RNA in the serum. Recommendations include [7]:
 - Begin testing for HCV antibodies, HCV RNA levels, and alanine aminotransferase (ALT) levels immediately after the event.
 - Repeat testing 2-8 weeks later.
 - If infection occurs, the health care worker should be referred to a specialist for management.

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Health Law

HIV and Health Law: Striking the Balance between Legal Mandates and Medical Ethics

by Laura Lin, MBA, JD, and Bryan A. Liang, MD, PhD, JD

HIV status and reporting requirements raise legal issues related to patient confidentiality. Legal protection of patient privacy and confidentiality depends on whether or not public health concerns outweigh the interest in preserving the doctor-patient privilege. The balancing of these interests is a particular challenge when it comes to privacy concerns associated with HIV status.

A core legal dilemma in the case of HIV/AIDS is determining when the need to protect others, such as sex partners to whom the patient is likely to transmit HIV, supersedes the patient's right to confidentiality. Public policy encourages high-risk groups to submit to HIV testing because those individuals who know they are HIV-positive are more likely to seek treatment and take precautions that may prevent transmission of the virus. However, if HIV-related information is readily disclosed by health care providers, individuals may become more reluctant to seek testing. When does the protection of others through a breach of patient confidentiality, ie, reporting cases to the authorities, become worth the risk to that individual who may be HIV-positive will avoid testing in order to avoid being reported?

Reporting Requirements

All 50 states require both physicians and laboratories to report to local or state health departments the names of persons newly diagnosed with Centers for Disease Control-defined AIDS [1]. However, because AIDS cases represent onset of the disease caused by HIV, HIV data is necessary to monitor the epidemic.

But HIV reporting requirements currently differ among states. The 3 main HIV reporting systems are name-based reporting, code-based reporting, and name-to-code-based reporting. In code-based reporting, coded identifiers are substituted for names. Name-to-code-based reporting means that cases were initially reported by name, but were converted to code after public health follow-up and collection of epidemiologic data.

In 1999, the CDC recommended that all states implement HIV reporting systems; however, the CDC does not accept HIV reporting data from the 9 states that use code-based systems due to their unreliability [2]. Beyond their use as an epidemiologic tool, reliable data are important under the reauthorization of the Ryan White CARE Act, since the federal government may include CDC-confirmed HIV case data in applying the Ryan White CARE Act funding formula [3, 4].

Forty-three state (including New York, Florida, Texas, Ohio, and New Jersey,) and local health departments have implemented confidential name-based HIV reporting [5], while approximately 14 other state and local health departments use code-based or name-to-code reporting methods [6]. States that use name-to-code systems include Oregon and Washington; California and Massachusetts use a code-only system [7]. Some states, Texas and Kentucky, for example, that once used code-based HIV reporting, have changed to name-based systems.

Many argue that code-based reporting systems are not as effective as name-based systems and have prevented physicians and public health officials from contacting those who have had sexual contact or shared needles with HIV-positive individuals. [8]. Such results have produced demands for more name-based reporting for the purposes of tracking, public health, and allocation of resources for outreach.

Reporting Risk to Known Contacts

Partner notification is critical so that individuals know they are at risk, receive HIV counseling and testing, and get appropriate medical care. One of the most controversial issues is whether physicians may disclose the HIV status of their patients to known contacts and, further, whether failure to do so may give rise to liability if the known contact becomes HIV-positive. Though the threat of the contact is clear and immediate, individuals may be discouraged from undergoing testing if they know someone will notify contacts.

In other contexts, physicians have faced liability for not warning third parties of foreseeable harm. For example, a California court held that a psychotherapist had a legal duty to warn a third party of foreseeable harm, despite the presence of the client-therapist privilege [9]. A Tennessee Court held that a physician has a duty to warn possible third parties of the risks of exposure to a noninfectious disease, ie, Rocky Mountain Spotted Fever [10]. Thus, case law contains legal precedent that justifies dissemination of information to prevent third-party harm. Yet, to date, attempts to create a duty for physicians to protect endangered third parties in HIV cases have been unsuccessful. In 2 such cases, the courts refused to impose an affirmative duty on the physicians to notify a third party. Both parties sued, alleging intentional infliction of emotional distress because of their fear of contracting AIDS [11]. Laws to determine the boundaries of liability and reporting in HIV and AIDS will have to be developed because, clearly, there are conflicting legal doctrines at work in the mandatory reporting case law that judges have made.

State Statutes

To add to the confusion, state statutes vary as to whether a patient's HIV status can be disclosed to contacts. Many states have laws about informing contacts of their HIV exposure, and some health departments require that if a patient refuses to report a partner who may have been exposed, the clinician *must* report to the health department any partner of whom the clinician is aware [12]. Some states also have laws mandating a duty to warn, thus requiring disclosure by clinicians to third parties known to be at significant risk for future HIV transmission from patients known to be infected [12].

And health departments that receive Ryan White funds are required to show good faith efforts to notify marriage partners of HIV-infected patients [12].

Overall, state statutes generally fall into 3 types: (1) some state statutes mandate that the physician provide the contact's name to the state health agency; the state health agency then notifies the contact; (2) some states give the physician the choice of notifying either the state health agency or the third-party contacts directly; and (3) other states make such disclosures to a state agency optional [13]. The tremendous variation of these provisions indicates that physicians should always seek advice from public health departments and their own attorneys to understand their legal responsibilities.

Disclosure and HIPAA

When disclosure is appropriate or required, physicians should disclose HIV/AIDS information, which is protected health information, in accordance with its extremely confidential nature as required by city, state, and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

A number of lawsuits have been filed by individuals who claim, among other things, that the information regarding their condition was disseminated publicly and needlessly. Furthermore, punitive damages have been allowed for wrongful disclosure of a plaintiff's HIV status in violation of a confidentiality statute [14]. However, reports to public health agencies and other public health authorities under state regulations are not violations of HIPAA. Further, sharing of HIV and AIDS information for the purposes of treatment, payment, or health care operation functions such as quality assurance and improvement is also permitted under the federal privacy rule. Therefore, physicians should not hesitate to follow the provisions of reporting requirements since appropriate reporting will not violate the HIPAA provisions for patient privacy.

Ethics Considerations

Ethical issues are associated with any discussion of HIV reporting and contact notification. Ethical principles that come into conflict include the right to know, the right of confidentiality and privacy, protection against discrimination, the duty to warn, and the duty to protect the public health. While public health officials usually perceive being responsive to the greater good of the population as their duty, physicians see maintaining the bond between themselves and their individual patients as their duty. Mandatory reporting requirements may seem to conflict with the physician's ethical obligations, including the Hippocratic Oath, which prohibits inappropriate disclosure of any kind of personal health information.

However, the AMA *Code of Medical Ethics* Opinion 5.05 states that information disclosed to a physician by a patient is confidential but subject to certain exceptions that are ethically and legally justified because of overriding societal considerations:

Where a patient threatens to inflict serious bodily harm to another person or to him or herself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities [15].

The *Code* also notes that communicable diseases should be reported as required by applicable law. This utilitarian approach fulfills the physician's duty to be an agent of the individual patient but in the context of the potentially greater good of the society in which he or she practices.

Specifically with regard to HIV-infected patients, exceptions to confidentiality do exist. As stated in Opinion E-2.23:

If a physician knows that a seropositive individual is endangering a third party, the physician should, within the constraints of the law (1) attempt to persuade the infected patient to cease endangering the third party; (2) if persuasion fails, notify authorities; and (3) if the authorities take no action, notify the endangered third party [16].

As a policy matter, the AMA strongly recommends that all states adopt requirements for confidential HIV reporting to appropriate public health authorities for the purpose of contact tracing and partner notification [17]. The AMA encourages uniform protection of the identity of HIV patients that is consistent with public health departments and vows to continue to address, through the Council on Ethical and Judicial Affairs, the patient confidentiality and ethical issues raised by known HIV-positive patients who refuse to inform their sexual partners or modify their behavior [17]. The AMA also supports legislation on the physician's right to exercise ethical and clinical judgment regarding whether or not to warn unsuspecting and endangered sexual or needle-sharing partners of HIV-infected patients and promulgates the standard that a physician attempt to persuade an HIV-infected patient to cease all activities that endanger unsuspecting others and to inform those whom he or she might have infected. As stated above, if such persuasion fails, the physician is urged to pursue notification through means other than by reliance on the patient, such as by the Public Health Department or by the physician directly [17].

The tension between reporting and confidentiality in HIV and AIDS cases is difficult for physicians. Although the ends of the spectrum may provide for relatively clear action—such as when an infected patient is known to engage in unsafe sexual practices without disclosure—the discussion of HIV disclosure is a difficult issue. Patients may be debilitated and physically vulnerable and may be subject to significant insurance and social discrimination if HIV status is wrongfully disclosed.

Physicians must be cognizant of their patients' circumstances and the sensitivities surrounding the discussion of HIV disclosure. This means that they should know their patients well and follow the well-worn aphorism to treat the patient as an individual, rather than as simply a disease. Although the discussions may not be any easier or the

actions any less difficult to take, the path toward fulfilling the needs of the patient—and the society in which we all live—may become more clear. Ultimately, this approach will bring the physician-patient relationship back to the fundamentals: to a foundation of trust and open communications that can result in the best outcome for the patient.

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Policy Forum

From Research to Policy: Expedited Partner Therapy for Chlamydia

by Jeffrey D. Klausner, MD, MPH

In September 2000, the governor of California signed into law Senate Bill 648 which authorized physicians in California to dispense enough extra medication to patients infected with Chlamydia to treat their sex partners [1]. The Centers for Disease Prevention and Control recently recommended that this practice of expedited partner therapy be a key component of the medical management of urogenital chlamydial infections [2].

Background: The Problem of Chlamydia

Chlamydia trachomatis infection is one of the most common sexually transmitted diseases (STDs) in the United States, affecting 5-10 percent of sexually active adults. It is the infectious disease most frequently reported to the Centers for Disease Control and Prevention [3]. Annually, there are about 2.8 million cases [4]. Left untreated, Chlamydia can cause pelvic inflammatory disease, ectopic pregnancy, and infertility. Chronic chlamydial infection may also increase the risk of acquiring and spreading HIV infection [5].

To reduce the continued transmission of Chlamydia it is important to prevent reinfection and treat sex partners of infected patients. Prior research has shown that repeat infection frequently occurs in treated patients within 3 months [6]. Effective control of sexually transmitted diseases has always included efforts by public health authorities to inform, evaluate, and treat sex partners who may have been exposed. Doctors should know which sexually transmitted diseases (such as chlamydial infection, gonorrhea, and syphilis) are reportable in their state and that laboratories are mandated to report positive cases of those STDs to the health department without the explicit permission of the doctor or patient.

The Role of Public Health

Since the capacity of the local health department to respond to STD reports is highly variable and the majority of health departments do not have adequate resources to follow up with sex partners of patients infected with Chlamydia, the burden of treating those partners rests mainly with the doctor.

Current public health policy has made the most of patients' interest in taking a proactive role in their health and the health of the community by enabling them to deliver safe and effective treatment to their partners. That practice is considered both logical and utilitarian, offering the greatest good for the greatest number of persons. It is, however, contrary to standards of medical practice that, in most states, prohibit

prescribing medication without a good faith examination. Some states also prohibit the sharing of prescription drugs.

Standards of medical care that require a medical history and physical examination before prescribing make sense when a diagnosis is uncertain, the treatment potentially dangerous, or the costs of treatment outweigh the potential benefits to public health. The Centers for Disease Control and Prevention, however, recommend that all sex partners of persons with a diagnosis of Chlamydia, gonorrhea, and syphilis be treated based on their epidemiologically linked exposure. While a medical history may be necessary to reduce the risk of an allergic reaction or a drug-to-drug interaction in a patient, with the currently recommended treatments for Chlamydia [7] (azithromycin 1 gram once by mouth) those events are rare, and the community benefit of reducing disease transmission may outweigh the risk of an infrequent event like an adverse drug reaction in an individual patient. Physical examination does little to mitigate the likelihood of adverse drug events but could be useful in excluding concomitant illnesses or more serious complications of infection (for example pelvic abscess or pelvic inflammatory disease).

The Role of Research

Given the logical and ethical rationale for treatment of sex partners of persons with sexually transmitted diseases, why is research necessary to further justify public policy in favor of the practice? The answer is that the practice of medicine and public health is ideally based on sound scientific evidence that demonstrates the efficacy, risks, and benefits of a specific intervention.

As with clinical trials, the first priority in public health is to demonstrate that a practice is feasible and safe. After safety has been established, clinicians must evaluate efficacy, and, ultimately, they must determine how the intervention performs in the real world. Our first study was an observational one which demonstrated that, in a municipal clinic for sexually transmitted diseases, about 30 percent of patients accepted extra medication to give to sex partners [1]. In a follow-up study about 70 percent of those who accepted treatment reported giving it to their sex partners, and no adverse effects were reported. Those observational studies occurred at the same time that efficacy studies were started which showed that patient-delivered partner therapy was safe and might be associated with a 20 percent reduction in the rate of reinfection [8]. Subsequent studies showed greater efficacy with patient-delivered partner therapy, now called expedited therapy, reducing the rate of reinfection by 24 percent [9].

Based on this strong evidence, the CDC will likely recommend in the 2006 version of the STD treatment guidelines that expedited partner therapy become standard practice in the management of all patients infected with Chlamydia and gonorrhea.

Intersection between Research and Policy

A major reason why research must inform public policy is that the practice of public health is political. Everyone has an opinion about what is the right balance between individual health, autonomy, and privacy, on the one hand, and the health and welfare of the community, on the other. That balance had shifted over time in the United

States from the decades of truly progressive social hygienists (1920s and 1930s) to the “me” generation of the 1980s and 1990s. In one era, mandatory syphilis testing made sense, while in another, an individual’s right not to immunize his or her children was upheld. Current policy makers want to see the cost, the benefits, and the data on which public health recommendations are based to justify decisions to critics and to gain backing from supporters. The requirement for research to inform public health policy is, however, not without its costs, particularly in time and lost opportunity. It can take years for research to be adequate—multiple studies are necessary in a variety of populations, and that delays the potentially valuable implementation of policy. Policy that entails a lower cost and less controversy (eg, dietary recommendations for children) might be implemented more quickly than policies that are more invasive and permanent (eg, male circumcision to prevent HIV transmission).

Conclusion

In summary, research is a critical element in the development of sound public health policy, but the requirement for adequate research can delay timely implementation and result in missed prevention opportunities. Conducting research that impacts public policy is highly rewarding when the goal is less the advancement of science than the practical protection of public health. Research leading to the dissemination of results in widely read periodicals may be more worthwhile than that published in the most competitive medical journals. Public health needs greater evidence on which to make policy recommendations and more researchers interested in providing that evidence. The future of the health of our community depends on it.

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Medicine and Society

Demography and Contemporary Influences on Sexual Behavior

by Sevgi O. Aral, PhD, MSc

Recent years have brought unprecedented changes to human life and its physical, social, and economic context. Given the increased interconnectedness of populations, people all over the world may be affected by events that take place in an area far away [1-3]. Technological and related changes in public health and medicine have resulted in interconnected and parallel changes—2 great demographic transitions.

First Demographic Transition: Population Growth

Two centuries ago the rise of modern science and technology dramatically reduced disease and famine in Europe and North America, in turn reducing mortality and triggering a sustained and unprecedented growth in population, followed by declines in fertility. This change in mortality, fertility, and population growth has been called “the first demographic transition.”

Second Demographic Transition: Post-industrial Era

The post-industrial age is marked by below-replacement fertility levels, aging populations, and decreasing population size. Current estimates suggest that demographic growth rates are declining nearly everywhere, even more rapidly than was earlier projected [4]. Regional growth rates differ, but international migration redistributes a considerable portion of the continuing natural increase [5]. This post-industrial stage of global demographic transition, “the second demographic transition” [6] is characterized by decreases in the total first marriage rate; large increases in mean age at marriage and childbearing; divorce and union dissolution; cohabitation; proportion of extramarital births; and maternal employment [7-11]. In addition, post-industrial societies have experienced large decreases in period and cohort fertility.

Changes in the Structure of Marriage and the Family

In industrialized countries, the structure of marriage and the family has been undergoing major change since the beginning of the 1970s [7]. Mean age at marriage and at childbearing have been increasing—by an average of 2 years in some places. The total divorce rate is near or above 30 per 100 marriages in most industrialized countries and spiked upward between 1980 and 1999 [7].

In Europe many women choose not to marry, and the average age at the time of first marriage is increasing; the marriage rate has decreased by 40 percent from 1960 to 1995 [12]. From 1981 to 1996 in urban centers in Europe, the size of the average household declined from 2.8 persons to 2.3 persons; the number of people living

alone increased from 27 percent to 38 percent; and the proportion of single-parent households increased from 6.5 percent to 7.5 percent [13].

Similar trends are observed in the United States; the percentage of adults aged 15 and older who were married declined from 69.3 percent and 65.9 percent for men and women, respectively, in 1960 to 57.1 percent and 54 percent in 2003 [14]. Conversely, over the same time period, the percentage of men and women aged 15 and older who were divorced increased from 1.8 percent and 2.6 percent in 1960 to 8.3 percent and 10.9 percent in 2003 among men and women, respectively [14]. Family households had predominated in the United States—81 percent of all households in 1970 were family households, but this proportion dropped to 68 percent by 2003 [15].

Changes in Values, Attitudes, and Expectations

The demographic shifts of the second demographic transition were accompanied by large-scale changes in values and attitudes. Emphasis on values such as individual autonomy, self-fulfillment, tolerance, democratic decision making, individual freedoms, and individual rights increased [16]. The roles and expectations of women changed: women are less likely to stay in abusive or unhappy marriages; they assume equal rights to education and work outside of the home, and they expect an enjoyable sex life with control over their fertility via “the pill” and other means [3].

Technology and Its Consequences

Cell phones and the Internet constitute important technological developments with significant effects on the ways in which people relate to each other. In the late 1980s and early 1990s cell phones revolutionized the social organization of sex work. The remarkable growth of cyber-brothels changed the way sexual services are provided, and chat rooms have supplied a powerful mechanism for sexually connecting men who have sex with men, in contracted time and space.

The role of the Internet in sexual behavior is still evolving. An increasing number of people use the Internet to find dates and potential marriage partners, *and* an increasing number of people use it to identify one-time partners.

Changing Sexual Behaviors

Data collected between 1995 and 1997 in Chicago showed that, in the mid-1990s, Americans aged 18 to 59 spent 50 percent of their lives as singles, longer than ever before. They were in the “sex market” for longer periods and at older ages; cohabited on average for 4 years; were married an average of 18 years; and dated or searched for a partner an average of 19 years.

All the changes discussed above are revolutionizing the pattern of sexual unions, the sex structure of society, and sexual behaviors. In general people are living outside of traditional monogamous marriages for longer periods of their lives, have control over their fertility, and expect an enjoyable sex life. The net effect of these transformations on sexually transmitted infection epidemiology and sexual health will unfold in the coming decades.

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Medicine and Society

Sex Education in the Public Schools

by Robynn Barth

Today's kids are inundated with sex. There is nudity on the Internet, sex in the movies, and intimations of sex in popular music. All schools and teachers face the problem of how to help these kids grow into sexually healthy adults by encouraging safe behaviors without stepping on the toes of their parents. Two types of sex education programs have evolved in response to this challenge—abstinence-only sex education and abstinence-plus (sometimes called “comprehensive”) sex education.

How the Curricula Differ

The 2 types of curricula share the same strong message: *the only sure means of avoiding teenage pregnancy or sexually transmitted diseases (STDs) is abstinence*. Where they differ is whether or not they include discussion of contraception. Joe McIlhaney, Jr, MD, of the Medical Institute for Sexual Health, is a prominent spokesman for abstinence-only programs. He explains that the only information these programs provide about contraception is its failure rates [1]. In the mind of an adolescent, critics say, this equates to saying about contraceptive devices, “they don't work, therefore don't use them.” In most schools, though, abstinence-only education means “*we definitely won't talk about contraception*.”

A Boom in Abstinence-only Programs

In 1996, President Bill Clinton signed into law the “welfare reform act,” which appropriated \$50 million in funds for school-based sex education programs that focused exclusively on abstinence as a means to prevent pregnancy and STD transmission. Since then, there has been an influx of published curricula as federal funding for abstinence-only education has shot up: \$80 million in 2001, and \$167 million in 2005. President Bush's proposed 2006 budget appropriates \$206 million for these programs [2]. This is exciting news for most districts; it equates to free teaching materials. Yet any school choosing the “abstinence-plus” format will not receive any of this federal money.

Problems with Current Studies of Abstinence-only

After the initial funding boom many states instituted a variety of abstinence-only programs, prompting myriad studies to assess the effectiveness of the curricula. Advocates for Youth compiled evaluations from several states after the first 5-year funding cycle came to a close. Their conclusion was that the programs implemented showed “little evidence of sustained (long-term) impact on attitudes” toward sex [3]. They also asserted that the evaluations showed “some negative impacts on youth's willingness to use contraception, including condoms.” The curricula evaluated in the

Advocates for Youth study, as well as other abstinence-only material, face a huge limitation: none has been around long enough to show evidence of success in delaying sexual initiation among youth.

A second problem in determining which format is more successful is that the 2 types of curricula are not being compared to each other in any studies. Dr McIlhaney's studies publicize success with the abstinence-based programs, but typically the abstinence-only curricula are being compared to simple abstinence lectures [1]. Studies have found that 1 year later, students who experienced the curricula have a significantly better understanding of the importance of abstinence than students who received the lecture. That should go without saying.

States are saying “No” to abstinence-only curricula.

Douglas Kirby, PhD, an authority on abstinence-plus sex education, has reviewed research on a wide range of curricula. He identifies 10 common characteristics of effective sex education programs [4]. My home state of Washington has chosen to base its *Guidelines for Sexual Health Information and Disease Prevention* on these distinctive attributes. Washington is one of many states that encourages its schools to adopt a more comprehensive approach to sex education and, in so doing, to forgo the federal funding available for implementing abstinence-only curricula. This particular subject area is the only one that is state-mandated; the law states that all schools shall provide “the minimum requisites for good health including the beneficial effect of physical exercise and methods to prevent exposure to and transmission of sexually transmitted diseases” [5]. The state further identifies guidelines for human immunodeficiency virus (HIV) education in The Acquired Immunodeficiency Syndrome (AIDS) Omnibus Act. This law requires that all students, beginning no later than the fifth grade, must receive education on the dangers of AIDS, its transmission, and its prevention [6]. The state provides HIV education curricula for grade levels 5-12 and requires that school districts either use it or develop their own and get it approved for medical accuracy by the state Department of Health Office on HIV/AIDS [7].

How a District Decides What to Teach

The number of different-but-really-the-same curricula available is overwhelming. Many districts decide to reuse a previously adopted health textbook (which may be from 2002 or may be from 1993, depending on appropriation of funds). There are also supplemental materials available from acne and feminine product companies; they provide fun, puberty-related materials with their corporate name plastered on them (a form of free advertisement). Some parents are uncomfortable having their children learn about sex in school, so most districts offer parents a way to “opt out” on behalf of their child. One district I worked in allowed a parent group to choose abstinence-only curricula and find community members to deliver it to students during the school day. Other districts leave it up to the individual schools to decide what to teach. In my district, there is a small high school with a high pregnancy rate. The health teacher told me that, when he was hired, the principal gave him the health textbook and told him to teach whatever he wanted to—except for the parts about the reproductive system. That administrator's discomfort with the subject has contributed to life-changing events for many families in our community.

Tips for Physicians

Physicians can greatly assist in teaching sex education by helping parents out of their denial. I believe that at each yearly physical exam during the adolescent years the physician should hand the *parent* a brochure about sex: how to talk about it, the rates of sexual behaviors based on age, and possible warning signs of sexual activity. Simply having such materials on a stand in the lobby does not help. No child wants to be seen with a parent who picks up that brochure, and not all parents realize they need to have that conversation with their child. If the physician sends a message to the parent with the kid present, no one can hide the elephant in the room.

What I Have Seen as a Teacher

Some of the abstinence-only studies show promising findings when, one year later, *middle school students* still have positive attitudes about remaining abstinent [8]. What they don't have are the responses from these same kids when they are juniors in high school. As the pressures to be sexually active increase, attitudes change. I have had discussions with quite a few middle school kids who believe they are safe because they are "virgins." What they fail to understand, and what *must* be taught to them and their parents as early as the 8th grade is that you don't have to have sexual intercourse to be infected by an STD. Every time I teach about STDs to a new group of 8th graders, I see looks of fear upon the faces of some of the girls. These looks give them away. Today's kids are having sex. We cannot control the sexual pressures they face, but we can shape their response to those pressures. We can do so by providing them with factual information about the transmission, progression, and prevention of sexually transmitted diseases. Their bodies are being run by that drill sergeant of a pituitary gland, and the hormones are completely in charge. If we don't fit in a few facts about the risks of following the sexual desire portion of these hormones, then we are doing a great disservice to these children and to our society.

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Op-Ed

American Academy of Pediatrics Report on Adolescent Pregnancy: Harmful by Omission

by Joe S. McIlhaney, Jr, MD

The recent American Academy of Pediatrics (AAP) Clinical Report, “Adolescent Pregnancy: Current Trends and Issues” [1], fails to consider the complete emotional and physical complexity that is adolescence and, as a result, advocates a clinical approach that can be harmful. To understand how to correctly address sexuality and the adolescent in the clinical setting, physicians must take a broader view than what is advocated in this flawed report.

The report makes the mistake that has marred the approach to adolescent sexual activity for 3 decades—an abhorrence of taking a position on the healthiest sexual behavior. I am not advocating that clinicians render medical advice based on their moral judgment. However, when the data are abundant and clear that a certain behavior is unhealthy or harmful, then telling the patient he or she should avoid such a behavior is not a moral judgment.

For example, every clinician would tell an adolescent not to smoke, not because of the clinician’s moral sensitivities but because smoking is unhealthy. As this paper will argue, the same is true for adolescent sexual activity; it is unhealthy behavior, and, thus, every clinician should instruct adolescent patients to avoid it.

Unfortunately, the AAP clinical report refuses to advocate such a risk avoidance stance because walking the middle ground and taking no stance on whether adolescents should remain abstinent is both politically neutral and politically easy. Unfortunately, this is unacceptable—clinicians are required to instruct their patients on what is healthy. In this case, only avoiding sexual activity during adolescence is healthy.

The Case for Abstinence for Adolescents

Adolescence starts at puberty and ends with the final maturity of the prefrontal cortex, roughly in the mid-twenties. The AAP clinical report presents pregnancy as the major risk of sexual activity during this period of time, ignoring the impact of sexual activity on the social, emotional, and physical development of adolescents. Beyond the risk of pregnancy or fathering a child, sexual activity is dangerous behavior for people of this age. Consider, for example, the epidemic of sexually transmitted diseases (STDs):

- More than 60 million Americans are currently infected with an STD, and about 19 million new cases occur every year. One quarter of these new STD

- infections occur in people between 15 and 19, and half occur in those under the age of 25 [2].
- Human papillomavirus (HPV) is 1 of the most common STDs in the United States. In one recent study, about 50 percent of sexually active 14- to 17-year-old women were infected with HPV [3]. HPV is the cause of 99 percent of cervical cancer cases and 99 percent of precancerous pap smears. This cancer is responsible for approximately as many deaths among women every year in this country as is AIDS [4,5].
 - Even 100 percent consistent and correct use of condoms (which is uncommon, especially among adolescents) at best *reduces* but does not *eliminate* the risk of STDs. There is virtually no evidence that condoms reduce the risk of HPV, though they may somewhat decrease the number of people who develop warts or cervical cancer [6].
 - One hundred percent consistent use of condoms only reduces the risk of chlamydial and gonorrheal infection by about half. Approximately 700 000 new cases of infection caused by Chlamydia and 360 000 cases of gonorrhea are reported yearly in the US [2]. Reports show that approximately 10 percent of sexually active adolescent females are infected with Chlamydia, a leading cause of infertility.

Social and Emotional Consequences for Teens

Focusing only on the physical consequences of sexual behavior for adolescents, a mistake made by the AAP clinical report, can be harmful because it neglects serious negative social and emotional consequences. For example, an analysis of the National Longitudinal Survey on Adolescent Health (Add Health), the largest data set examining adolescent behaviors, reveals that sexually active adolescents, both boys and girls, are far more likely to be depressed and to attempt suicide than youth who are still virgins. A quarter (25.3 percent) of adolescent girls who are sexually active report being depressed all, most, or a lot of the time, compared to only 7.7 percent of girls who are not. Among boys, 8.3 percent who are sexually active say they are depressed all, most, or a lot of the time, while only 3.4 percent of adolescent boys who are not sexually active report the same [7].

The same data reveal that 14.3 percent of girls who are sexually active report having attempted suicide, compared to 5.1 percent of teenage girls who are not. Six percent of adolescent boys who are sexually active report having attempted suicide, compared to just 0.7 percent of boys who are not sexually active [7]. Even when the researchers controlled for background variables, the differences remain. “When teens were compared to other teens who were identical in gender, race, age, and family income, those who were sexually active were significantly more likely to be depressed and to attempt suicide than were those who were not sexually active,” the researchers write [2].

Furthermore, sexually active adolescents themselves report that they wished they had waited until they were older before commencing sexual activity. A poll by the National Campaign to Prevent Teen Pregnancy asked teens, “If you have had sexual intercourse, do you wish you had waited longer?” Nearly two-thirds of those who said

they had engaged in sexual intercourse reported that they wished they had waited longer before becoming sexually active [8].

Married Adolescents

These risks are not the same for married adolescents. Data at the population level, by researchers in the book *Sex in America*, shows that most people do not have sex outside marriage, which is a highly protective behavior against STDs [9]. Married adolescents avoid new STD risk when they are faithful in a marriage with an uninfected partner.

The Correct Clinical Response

Many adults who could influence the behavioral choices of adolescents (parents, educators, doctors) wrongly assume that they can have little, if any, impact on a teenager's decision to become sexually active. Too many adults simply assume the inevitability of adolescent sex. Indeed, the AAP clinical report seems to be based on this assumption. This is an unfortunate, actually tragic, abdication of responsibility to America's adolescents.

The fact of the matter is that adolescent sexual activity is not inevitable. Parents and other adults can have great influence on the decision an adolescent makes regarding if and when to become sexually active. It is appropriate and necessary that they do so. Analysis of the Add Health data reveal that teenagers are more likely to avoid sexual activity if they experience a high level of parent-family "connectedness" and if their parents express disapproval of their becoming sexually active [11].

The majority of adolescents today are virgins. According to the Centers for Disease Control and Prevention (CDC) [10], 53.3 percent of high school students have never had sexual intercourse. This is a reversal of the data from approximately a decade ago.

Role of the Pediatrician

Pediatricians have a responsibility to discuss sexuality with adolescent patients in a way that addresses its physical, social, and emotional consequences. The pediatrician must ensure that patients understand all of the risks of engaging in sexual behavior at their age, including but not limited to the risks of STDs, pregnancy, and negative emotional feelings and states. This includes understanding the limits of condom effectiveness in preventing the spread of STDs. But data clearly shows that information alone does not change behavior.

Pediatricians should help their adolescent patients understand normative age-appropriate behavior when it comes to sex. Popular culture, especially the media, too often presents an "everybody is doing it" picture of adolescents and sex, leading teenagers to conclude that normative behavior for them and their peers is to engage in sexual intercourse. Relying on such sources as the CDC, pediatricians can help adolescents understand that, contrary to popular misconception, choosing to postpone sexual activity until later is normative and is necessary behavior for the healthiest future.

Finally, pediatricians can help parents of adolescents understand that they can have great influence upon their children's choices when it comes to risky behaviors, including and especially sex. Too many parents, either because they don't know how to be involved or don't realize they can make a difference, fail to adequately express their expectations to their adolescent children. Pediatricians should make sure that the parents of all of their adolescent patients are equipped to talk to their children about sex, especially telling their children that they disapprove of sex during adolescence.

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Op-Ed

Teens Deserve More than Abstinence-only Education

by Debra Hauser

Each and every day in the United States, some 10 000 teens contract a sexually transmitted disease [1], 2400 get pregnant [2], and, tragically, 55 contract human immunodeficiency virus (HIV) [3]. The reasons for these problems are complex and defy simplistic solutions. Yet, since 1998, the United States has spent over \$1 billion in federal and state funds to support ineffective abstinence-only-until-marriage programs—programs that censor educators from providing life-saving information about the health benefits of contraception and condom use for sexually active youth. In fact, discussion of condom effectiveness within a federally funded abstinence-only-until-marriage program is restricted by federal regulation. [4,5].

Support for Comprehensive Sex Education

The overly simplistic "just say no" approach to teens and sex is unrealistic and dangerous. Censoring vital information that young people need to protect their health endangers their lives. As early as September 2000, the Institute of Medicine (IOM), created by Congress to advise the nation on scientific issues, released a report calling on that very body "to eliminate requirements that public funds be used for abstinence-only education" [6]. The IOM further recommended "age-appropriate comprehensive sex education and condom availability programs in schools" to help young people reduce their risk of contracting HIV [6]. Later that same month, the Office of National AIDS Policy released a similar report, stating, "It is a matter of grave concern that there is such a large incentive to adopt unproven abstinence-only approaches. Effective programs identified to date provide information about safer sex, condoms, and contraception, in addition to encouraging abstinence" [3].

Further, the American Medical Association, American Academy of Pediatrics, Society for Adolescent Medicine, American College of Obstetricians and Gynecologists, and more than 100 other leading public health and medical institutions support a more comprehensive approach to sex education—one that includes information about both abstinence *and* contraception [7-11].

Concerns about Abstinence-only Education

Two recently released reports show the danger of abstinence-only programs. A 2004 report compiled at the request of Representative Henry A. Waxman (D-Calif.) found that 80 percent of the most popular curricula used by federally funded abstinence-only education programs distorts information about the effectiveness of contraceptives and condoms, misrepresents the risks of abortion, blurs religion and science, treats stereotypes about girls and boys as scientific fact, and contains basic scientific errors [12].

A report compiled by Advocates for Youth in 2004, further demonstrated the ineffectiveness of these programs [13]. Advocates reviewed all available evaluations of state-based abstinence-only programs and found that, of the 10 states with evaluations, few demonstrated any short-term benefits and none demonstrated any lasting, positive impact on young people's attitudes, intentions, or behaviors. A few programs showed mild success at improving attitudes and intentions to abstain. No program was able to demonstrate a positive impact on sexual behavior over time. Further, evaluations from Arizona and Ohio found that young people's attitudes and intentions to use contraception (or condoms) declined from pre- to post-test, indicating that abstinence-only programs may have a negative impact on young people's willingness to use contraception or condoms once they do become sexually active [14,15].

Recent evaluations of the impact of virginity pledges further demonstrate this potentially dangerous program effect. Studies published by Hannah Brückner and Peter Bearman indicate that taking a virginity pledge can help some young people to delay sexual initiation for up to 18 months. Once these young people break their pledge, however, they are less likely to use contraception or condoms, thus putting them at risk for unwanted pregnancy and HIV or other sexually transmitted diseases (STDs) [16,17].

Brückner and Bearman also found that, among sexually experienced youth, more than 88 percent of pledgers had broken their pledge and had sex before marriage. Once pledgers began to have sex, they had more partners in a shorter period of time and were less likely to use contraception or condoms than were their nonpledging peers. Rates of STDs among youth who had taken a virginity pledge varied little from rates among those who had never pledged. Further, data showed that among those who reported having only oral and anal sex, pledgers were over-represented, possibly to "keep their virginity intact" [19].

Health Benefits of Comprehensive Sex Education

For those concerned that teaching young people about contraception will induce them to have sex, research again is clear on this issue. Numerous reviews, including one by the IOM, found that programs that teach about both abstinence and contraception do not encourage sexual activity [6,18-20]. Further, the IOM report, *No Time to Lose*, concluded that programs that teach young people about abstinence and contraception demonstrate more success than do abstinence-only programs in delaying sexual activity among youth who have not had sex and at improving contraceptive use among teens when they do become sexually active [6]. Further, abstinence-only programs leave young people ill-equipped to make responsible decisions about sexual health or to provide informed consent for health care services.

Parents' Views

While some in Congress seem uncertain about the difference between educating young people to the importance of abstinence and *limiting* education to abstinence-only, parents are clear. A poll by the National Campaign to Prevent Teen Pregnancy shows that a majority of adults and teens support greater emphasis on encouraging teens *both*

to not have sex *and also* to use contraception [21]. A national poll by the Kaiser Family Foundation further revealed that 85 percent of parents want schools to teach information about condoms and 90 percent want schools to teach about other forms of birth control [22]. An Advocates for Youth/SIECUS (Sexuality Information and Education Council of the United States) poll, conducted by Hickman-Brown Associates, indicated that 70 percent of adults oppose federal funding for abstinence-only-until-marriage education [23].

Lessons from Abroad

Despite almost 15 years of decline in the teen pregnancy rate (declines that began long before Congress started appropriating widespread funding for abstinence-only), the United States continues to have the highest rates of teenage pregnancy, birth, and abortion in the industrialized world and some of the highest rates of STDs [24-26]. The US has nearly 11 times the teen birth rate of the Netherlands, over 74 times the teen gonorrhea rate of France, and nearly 8 times the abortion rate of Germany [27, 28]. Why are public health outcomes for teens so much better in these countries than in America? The answer is that these European countries have pragmatic, research-based policies and an open, honest approach to sex education in the home and at school [29-35]. Does all of this openness lead to promiscuity? To the contrary, European teens in these countries begin having sex at about the same time or later than do American teens. They also have fewer sexual partners and use contraception more consistently than do their American peers [36-38].

Ethical Considerations

Clearly, it is unethical to censor vital life-saving information from people who need it. Young people have the right to medically accurate, honest information about sex and sexual health. The American public wants a more comprehensive and realistic approach. Teens say they need more information about both abstinence and contraception [22]. Research shows that comprehensive sex education—education that includes information about *both* abstinence *and* contraception—is the most effective sex education for young people [39].

American teens deserve medically accurate, realistic, and honest information about sex. Anything less in the era of HIV and AIDS is not only naïve and misguided, but also irresponsible and dangerous.

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HIV/AIDS Stigma: Historical Perspectives on Sexually Transmitted Diseases

by Laura J. McGough, PhD

In 1728, the impoverished Flora Price applied to her local parish churchwardens in London for assistance. Charitable support was provided at local parishes to carefully screened applicants. During her interview, she admitted that she suffered from the “pox,” the common term for sexually transmitted diseases before physicians clinically distinguished between syphilis and gonorrhea. Instead of entering a hospital, she was sent to a workhouse, an institution created to correct “idleness,” which at the time was widely regarded as the root cause of poverty. At the workhouse, she received mercury treatments for her illness. Her male contemporaries, however, were far more likely than indigent females to be admitted to hospitals, which provided bed rest in addition to mercury treatment. Female patients suffering from this “foul disease” did not win the sympathy of churchwardens as easily as male patients did. All poor patients, male and female, had to suffer the indignity of publicly admitting their diagnosis. Meanwhile, wealthy patients could afford private, confidential treatment with minimal, if any, loss to their reputations [1].

Stigma and Health Care Systems

Historical cases about the “pox,” such as the above example, provide useful insights about how stigma is perpetuated for present-day clinicians who treat acquired immune deficiency syndrome (AIDS) patients. The pox was regarded as a curable disease after the mid-16th century [2]. Stigma nonetheless persisted and was reinforced in a variety of ways. As the case of Flora Price shows, the health care and social services systems themselves can contribute to stigma by offering different levels of care with varying standards of privacy, confidentiality, and comfort to patients. Since the wealthy can more successfully shield their disease while the poor rely on public resources, the association between disease and poverty becomes more closely linked. It is, in fact, a vicious, self-reinforcing circle, since poverty can also make people more vulnerable to disease. Stigma is embedded in these wider social processes of power and domination, inequality, and poverty [3].

The Problem of Treatment Failure

During the 17th century, physicians inadvertently perpetuated stigma by explaining cases of treatment failure as the result of the moral failings of the patient rather than of the limitations of the therapy [4]. Unfortunately, stigma thereby inadvertently impeded medical progress. Because they held patients responsible for treatment failure, physicians and the wider public had no reason to question the efficacy of available treatments. On the contrary, the 17th and 18th centuries were a lucrative

period for pharmacists and vendors of cures for the "pox" [1]. It was believed that medical therapies had only limited success in some categories of patients, such as prostitutes.

This historical case is also a reminder for physicians of today to be careful about how treatment failure for HIV/AIDS patients receiving antiretroviral therapy is explained to the wider public. Given the crucial importance of patient adherence to treatment for the success of highly active antiretroviral therapy (HAART), it is potentially tempting to explain treatment failure as the result of patients' irresponsibility, forgetfulness, or inability to lead a disciplined life. Aside from cost, 1 of the reasons cited by Andrew Natsios, the head of the United States Agency for International Development, for not providing HAART to Africans in 2001 was their alleged inability to understand and follow the treatment regimen [5]. After protests from AIDS activists in reaction to Natsios' comments, the Bush administration later reversed its stand and initiated its own treatment program focusing on 12 African (and 3 non-African) countries. The potential for discrimination still exists, however. Some physicians regard the poor as less capable of adhering to medication, although studies have shown that physicians are not successful at guessing which of their patients will comply with therapy [6]. When access to life-saving therapy depends on physicians' or public health officials' perceptions about whether an individual patient can successfully adhere to therapy, it becomes a crucially important ethical issue to separate assumptions about patients based on often clinically irrelevant issues from demonstrated evidence of patients' ability to adhere to treatment [7].

Stigma and Society

Stigma also persists and is reinforced through the wider society because it is linked to perceptions of a particular group's weaknesses and vulnerabilities. Disease is both a painful reality and a potent metaphor, widely used by writers, artists, and the everyday public [8]. In 15th- and 16th-century Venice, for example, the sexually transmitted disease that appeared in epidemic form was called the "French disease," named after the French army that had invaded and, to Italian observers, unleashed this new malady. Reactions to the disease were complicated by the subsequent loss of military and political power in the wake of this invasion. The disease itself became a symbol of military vulnerability, thereby increasing the stigma associated with it [9]. Reactions to HIV/AIDS are also complicated by a wider set of political and cultural associations: initially, with homosexuality and Haiti, then with Africa. Each of these associations brought significant cultural baggage, including the legacy of racism and colonialism [10]. As individuals, physicians can do little to change the wider context of stigma or the symbolic associations between diseases and colonized or persecuted peoples. Nonetheless, it is important for physicians to be aware of the wider context of HIV/AIDS stigma and to understand that stigma falls more heavily on some patients than others.

Conclusion

HIV/AIDS stigma is not easily "cured" through the introduction of effective therapies. In fact, stigma can be reinforced by the health care system itself when substantial inequalities exist in access to and quality of care. Treatment failure can

provide another means of reintroducing stigma by blaming patients who either fail to benefit from treatment or experience difficulty in following the treatment regimen. Finally, physicians should be aware that stigma is perpetuated by wider cultural associations between disease and social, political, or moral disorder, thereby presenting the patient with a heavy psychosocial burden in addition to the physical burdens of disease.

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