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POLICY FORUM

HIV Screening in Health Care Settings in the United States

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In 2006 the Centers for Disease Control and Prevention (CDC) recommended routine HIV screening in health care settings of all patients aged 13 to 64 years, irrespective of lifestyle or perceived risk behaviors [1]. As part of those recommendations, the CDC stated that separate signed informed consent and prevention counseling should not be required for HIV-screening programs in health care settings. Depending on the policy of the individual setting, patients would be provided with verbal or written information about HIV testing, told that testing was recommended as part of routine care, and afforded the opportunity to decline—"opt-out." Those recommendations represented a shift from previous policies that had encouraged testing only for persons at high risk for HIV infection or in health care settings with high prevalence of HIV. Previous testing policies usually required separate written consent and pre- and post-test prevention counseling [2].

Aspects of the CDC's 2006 recommendations have engendered considerable controversy, especially as they relate to the ethical principle of respect for autonomy. Several authors have discussed the ethics of universal HIV screening based on different paradigms, highlighting and weighing different benefits and risks [3-8]. In this article, we present the clinical and public health rationale for the 2006 recommendations and discuss several ethical considerations as they relate to the principles of beneficence, respect for autonomy, and justice, focusing especially on physicians' dual responsibility to patients and the public.

Beneficence

From both clinical and public health perspectives, the primary justification for HIV universal screening stems from the large number of infections that go unrecognized until late in the course of the disease. An estimated 1.1 million persons in the United States were living with HIV or AIDS in 2006, of whom 238,000 (21 percent) had not been diagnosed. In that same year, an estimated 56,300 were newly infected [9, 10]. Without treatment, the interval between infection with HIV and onset of AIDS averages 10 years. In one CDC study, 38 percent of newly diagnosed patients developed AIDS within 1 year of their first positive HIV test, indicating that the tests came long after their initial infection with the virus [11]. Many HIV-infected patients are not tested despite multiple encounters with the health care system [12].

Thus, the purpose of screening is to identify patients with undiagnosed HIV infection earlier to offer timely treatment and reduce transmission to partners. HIV screening is especially important now that significant advances in antiretroviral therapy (ART)

have made the infection a manageable chronic disease. Timely diagnosis and effective ART can yield a near-normal life expectancy. ART provides an average per-person survival benefit of 160 months, much greater than that realized by medical interventions for other serious medical conditions such as comprehensive care following myocardial infarction (50 months) [13].

In addition to the health care and quality-of-life benefits associated with treatment, clinicians have a public health responsibility to prevent the transmission of infectious diseases. The prevention benefits from HIV testing are considerable. Persons aware of their HIV infection are 2.5 times less likely to engage in behaviors that transmit HIV than are HIV-infected persons who have not been tested [14]. Those unaware that they are infected account for 50 percent to 70 percent of new sexually transmitted HIV infections [15]. Thus, increasing knowledge of HIV status could substantially curb the epidemic, because infected persons take steps to protect their partners. Clinicians need to discuss with patients the importance of partner notification and the measures patients can take to minimize potential harm that might be associated with disclosing their HIV serostatus.

In short, universal HIV screening and early HIV diagnosis have a favorable benefit-risk ratio both to patients and public health. These benefits make universal HIV screening consistent with the ethical principle of beneficence.

Respect for Autonomy

Respect for autonomy is given preeminent ethical status, and informed consent is the practical application of this principle. To exercise respect for autonomy, clinicians must be able to communicate well with their patients, giving them adequate, comprehensible information that allows them to make decisions about testing or treatment options that shows respect for their right to privacy [16]. Clinicians must also ascertain whether patients assume that HIV screening has already occurred. Anecdotes suggest that patients may think that they have been tested for HIV when in fact they have not. Debate continues about the considerations for and against the need to have separate written consent for HIV testing and counseling [17]. Obtaining consent and providing counseling for an HIV test are influenced by concern for privacy, confidentiality, comprehension, and stigma. Because HIV testing has traditionally been encouraged based on risk factors that are stigmatized (e.g., same-sex behavior, multiple sex partners, injection drug use), opt-in HIV screening—asking for specific consent from asymptomatic persons—may be declined by persons who are concerned about disclosure of risk behaviors. In a New York survey, 39 percent of men who reported recent sexual contact with other men did not disclose this information to their health care professional [18]. Some patients worry that agreeing to an HIV test might be perceived erroneously as an admission of their engagement in high-risk behaviors. Opt-out screening (informing patients that they will be screened for HIV unless they decline) can minimize perceived prejudice or rejection, and thereby offer a more acceptable procedure for testing those who do not consider themselves at risk or who do not wish to discuss their sexual or drug-use behaviors.

It is possible that some patients might be tested for HIV unknowingly, due to lax procedures or lack of initiative. Health care settings should adopt appropriate safeguards and protocols to ensure that patients are not tested without their knowledge [8]. Published studies are limited, but it appears that many patients and clinicians agree that HIV should be equated with other chronic diseases—such as diabetes and elevated cholesterol—for which testing is routine, and for which written informed consent and pretest counseling constitute time and cost barriers in the clinical encounter [19]. Many patients indicate that they would be more likely to accept a test if testing were recommended as a general policy, rather than based on suspected risk behaviors. Patients prefer that HIV testing not be conducted without notification or discussion [19]. They also want to talk in depth with a clinician about HIV when the test result is positive [19].

The CDC's recommendation for opt-out screening in health care settings (where the doctrine of informed consent is well established) is intended to preserve the essence of informed consent and show respect for the right of patients to choose not only the testing and care that they would like to receive but also the information they wish to receive and disclose. Numerous studies have found that patients are most likely to accept testing when it is recommended by a clinician. Whether patients opt in or opt out, the end result should be the same: a voluntary and informed decision by the patient to accept or decline the health care professional's recommendation of an HIV test [17].

Evidence provides the impetus for national public health recommendations, but each state is responsible to interpret and implement recommendations based on its circumstances. When the CDC recommendations were issued in 2006, statutes or regulations in 20 states required separate written consent for HIV testing. Since 2006, 13 of those states removed the requirement (Arizona, California, Connecticut, Hawaii, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, New Hampshire, New Mexico, and North Carolina) [7]. Proposed similar legislation continues to provoke heated debate in the remaining 7 states (Massachusetts, Michigan, Nebraska, New York, Pennsylvania, Rhode Island, and Wisconsin) [7].

It is relevant to note that other HIV-related policies have evoked similar controversy and required time for adoption. For example, it was not until April 2008 that name-based reporting of HIV-positive status was adopted by all 50 states. State and federal health laws require providers to report cases of many communicable diseases to public health authorities. AIDS cases have been reportable by name in all states since 1986. The CDC recommended the use of name-based reporting of positive HIV status in 1999, when it was required in only 34 states. Although both state and federal public health laws protect privacy of patients, and staff members receive training in protecting safety and confidentiality of surveillance data, concerns about confidentiality fueled debate in many states until 2008 [20].

Justice

Universal screening is intended to reduce the stigma associated with targeted testing, which carries negative social and public health ramifications. Social stigma can result when certain subgroups of the population are assumed to be the ones who are infected with HIV, and opportunities for treatment and public health interventions can be missed entirely if we believe that only certain groups are likely to be infected. Universal screening can help eliminate the stigma associated with taking an HIV test, but stigma related to HIV infection persists and must be addressed. The goal of screening is to help identify patients with unrecognized HIV infection and allow them to avail themselves of relevant treatment and prevention services. To accomplish this overall goal, it is essential to ensure availability of and access to appropriate services for prevention and care. Access to prevention and care can pose a particular challenge to persons who may not perceive the value of early treatment, have difficulty adhering to a lifelong regimen of monitoring and treatment, or have limited resources.

In conclusion, clinical and public health benefits justify recommending and implementing universal HIV screening in health care settings in the United States. Ethical considerations for the principles of beneficence, respect for autonomy, and justice indicate that universal HIV screening in health care settings is warranted, provided that follow-up is assured and adequate prevention and care are accessible.

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