

## Controversies in HIV Testing: The Debate

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## New Recommendations

- **Routine HIV screening** test for all persons 13-64 in health care settings, not based on risk.
- **Opt-out** HIV screening with the opportunity to ask questions and the option to decline; include HIV consent with general consent for care.
- Prevention counseling in conjunction with HIV screening in health care settings is **not** required.
- Annual repeat screening of persons with known ongoing risk.

Revised Recommendations for HIV Testing  
CDC 9/21/06

## “Ins and Outs” of HIV Testing

- **Opt-In (Linked)**
  - Assessment for HIV risk done verbally.
  - Patient requests or is offered the test.
  - Explicit consent obtained, usually written.
  - Requires pre- and post-test counseling (often not done in real life).
- **Opt-Out (Delinked)**
  - Patient informed they will be tested for HIV along with routine blood work unless they ask not to be.
  - Counseling not required.
  - No separate consent.

## Opt-Out Not Legal in CA (yet)

- **Opt-out testing bill (Berg)** – allows opt-out testing without counseling
  - Allows routine testing in medical settings with general treatment consent
  - Requires patient to “be informed” that they will get an HIV test
  - Passed one house, likely to become law

## Wanda



- Waitress at Hooters
- Went to ER when she found one of these in her underwear
- While treated, she signed general release, was tested for HIV and was positive



## Wanda



- Wanda wondered what went wrong
- Found out her boyfriend is on the “down low”

### New Testing Recommendations:

**Needed Public Health Tool  
or  
Coercive Shortcut?**

#### Public Health Tool

### Case Finding

- Many (esp. young people and women) don't realize their risk, so don't know to ask for testing and are not being offered testing.
- More get tested with opt-out strategy.

### Awareness of HIV Status among Persons with HIV, United States

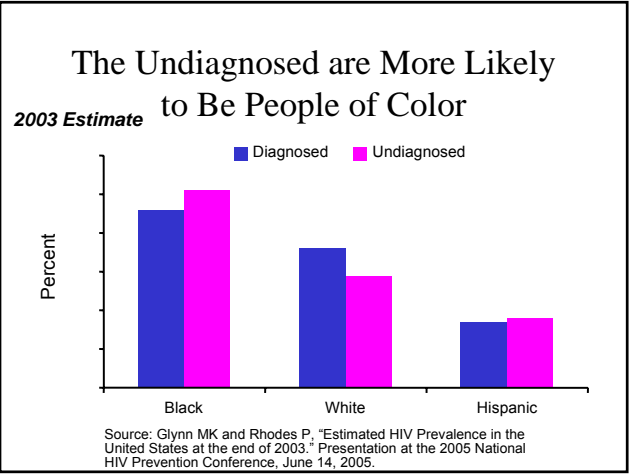
Number HIV infected 1,039,000 – 1,185,000

Number unaware of their HIV infection **252,000 - 312,000 (24%-27%)**

Estimated new infections annually 40,000

*Glynn M, Rhodes P. 2005 HIV Prevention Conference*

CDC/Janssen



### Routine Opt-Out HIV Testing Texas STD Clinics, 1996-97

	Opt-In N (%)	Opt-Out N (%)	% change
STD Visits	31,558	34,533	+9
Eligible Clients	19,184 (61)	23,686 (69)	+23
Pre-test counsel	15,038 (78)	11,466 (48)	-24
<b>Tested</b>	<b>14,927 (78)</b>	<b>23,020 (97)</b>	<b>+54%</b>
Post-test counsel	6,014 (40)	4,406 (19)	-27
<b>HIV-positive</b>	<b>168 (1.1)</b>	<b>268 (1.2)</b>	<b>+59%</b>

*Texas Department of State Health Services, 2005*

CDC/Janssen

### Case Finding

More testing will help find who is really infected and:

- Allow prevention resources to be focused on those communities.
- Increase testing outreach to those most at risk.

**Public Health Tool**

**Unrecognized HIV Infection Among 1,767 MSM**  
(Baltimore, LA, Miami, NYC, San Francisco)

Age Group (yrs)	Total Tested	HIV Prevalence		Unrecognized HIV Infection	
		No.	%	No.	%
18-24	410	57	(14)	45	(79)
25-29	303	53	(17)	37	(70)
30-39	585	171	(29)	83	(49)
40-49	367	137	(37)	41	(30)
≥ 50	102	32	(31)	11	(34)
<b>Race/Ethnicity</b>					
White	616	127	(21)	23	(18)
Black	444	206	(46)	139	(67)
Hispanic	466	80	(17)	38	(48)
Multiracial	86	16	(19)	8	(50)
Other	139	18	(13)	9	(50)
<b>Total</b>	<b>1,767</b>	<b>450</b>	<b>(25)</b>	<b>217</b>	<b>(48)</b>

MMWR June 24, 2005

CDC/Janssen

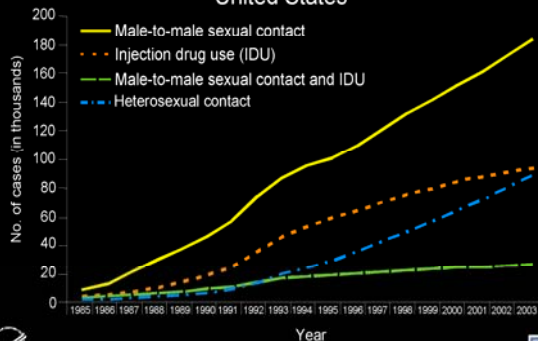
**Coercive Shortcut**

**Case Finding**

- Universal Testing wastes resources on testing low-risk people, rather than supporting prevention and treatment for high risk people.  
0.05% prevalence: \$50,000 per QALY
- Perpetuates history of sending resources to the “innocent victims”
  - MSM and IDU still at greatest risk!

Sanders G, et al. NEJM 2005;352:570

**Estimated Number of Adults and Adolescents Living with AIDS, by Transmission Category, 1985-2003 United States**



Note: Data adjusted for reporting delays and for estimated proportional redistribution of cases in persons initially reported without an identified risk factor.

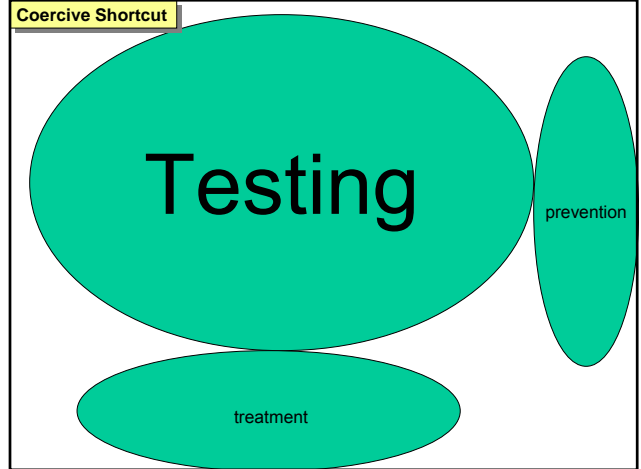
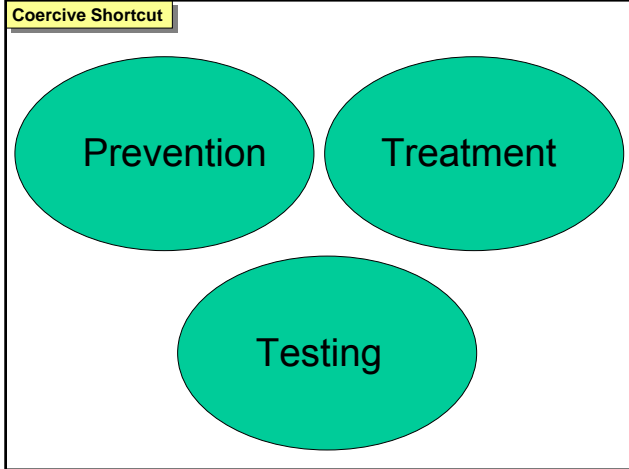


**Coercive Shortcut**

**Prevention**

- Testing without counseling ignores reducible risk.
- Behavioral prevention interventions *done correctly* can be effective.
  - New guidelines will move emphasis from prevention to medical intervention.
  - Current guidelines have not been fairly tested; insufficient resources invested to support real counseling in medical settings.

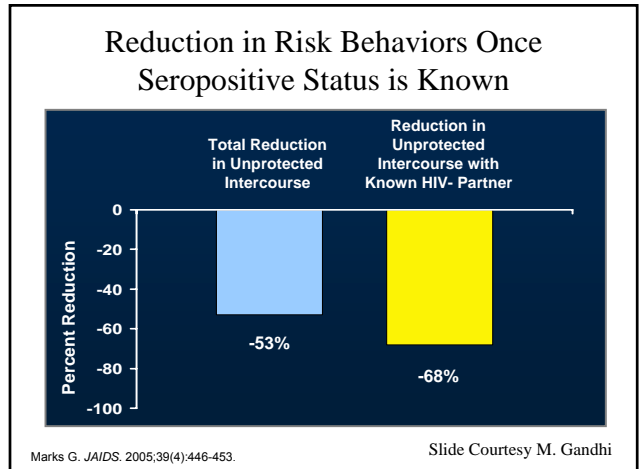
An Overview of the Effectiveness and Efficiency of HIV Prevention Programs  
Curran J; Public Health Reports, Vol. 110, 1995



Public Health Tool

### Prevention

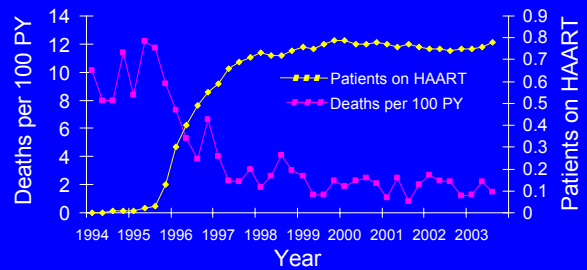
- Testing **IS** prevention.
- Current consent and counseling system is a barrier to testing.



## Medical Impact

- |   |  |
|---|--|
| <p><b>Individual</b></p> <ul style="list-style-type: none"> <li>Finds people <u>earlier</u> in disease             <ul style="list-style-type: none"> <li>treatment more effective</li> </ul> </li> </ul> | <p><b>Medical System</b></p> <ul style="list-style-type: none"> <li>Simplifies testing and outreach by:             <ul style="list-style-type: none"> <li>Incorporating consent in normal consent process</li> <li>Reducing counseling requirement for people at low risk, saves time.</li> </ul> </li> </ul> |
|---|--|

## Mortality and HAART Use Over Time HIV Outpatient Study, CDC, 1994-2003



-Palella et al, JAIDS 2006; 43:27.

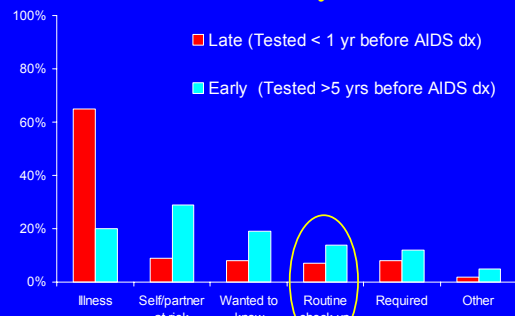
## Late HIV Testing is Common

Among 4,127 persons with AIDS\*:  
45% were first diagnosed HIV-positive within 12 months of AIDS diagnosis (“late testers”)

MMWR June 27, 2003

\*16 states

## Reasons for Testing: Late Versus Early Testers



CDC/Janssen

## Medical System Impact

- Providers perceive counseling as a barrier (survey of 54 providers/10 ED's)
  - 10% encouraged STD patients to get HIV test
  - 35% referred to outside testing
- Barriers cited: lack of follow-up (51%), believed they needed a counselor certification (45%), too time consuming (19%)

## Medical System Impact

- Too bad: resources should go to fix those problems, not ignore them.
- Providers misunderstand certification requirement.
- If 51% cite lack of follow-up as a barrier, that needs to be fixed in any case.

## Medical System Impact

- More people tested doesn't mean more people in care.
  - Have to be ready to receive care so focus should be on encouraging the desire/interest in testing
  - Delayed entry into care: median 3 month after testing, but 32% >2 yrs, 18% >5yrs
- Will people avoid medical care (ER, pre-natal) because they don't want to be tested?
- Increased costs from testing and getting more people in care; who will pay?

## Social/Ethical

More testing "normalizes" HIV and HIV testing, reduces stigma of testing.

## Opt-Out Screening and Stigma

### Prenatal HIV testing for pregnant women:

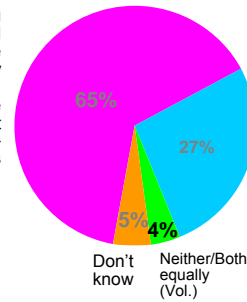
- RCT of 4 counseling models with opt-in consent:
  - 35% *accepted testing*
  - *Some women felt accepting an HIV test indicated high risk behavior*
- Opt-out testing offered as routine, opportunity to decline
  - 88% *accepted testing*
  - *Significantly less anxious about testing*

Simpson W, et al, BMJ June, 1999

CDC/Janssen

## Views on Routine HIV Testing

HIV testing should be treated just like routine screening for any other disease, and should be included as part of regular check-ups and exams



HIV testing is different from screening for other diseases, and should require special procedures, such as written permission from the patient in order to perform the test

Source: Kaiser Family Foundation Survey of Americans on HIV/AIDS (conducted March 24 – April 18, 2006).

## Social/Ethical

### ABA and ACLU:

- Violates civil rights by minimizing consent process.
- General medical consent is for care for which “risks and benefits are generally known.”
  - E.g. Genetic testing NOT covered by general consent.

DALLAS COUNTY  
HEALTH & HUMAN SERVICES  
S. T. D. CLINIC  
(SEXUALLY TRANSMITTED DISEASE)

ALL PATIENTS SEEN IN THIS CLINIC WILL BE TESTED FOR:

GONORRHEA  
SYPHILIS  
CHLAMYDIA  
HIV

CDC/Janssen

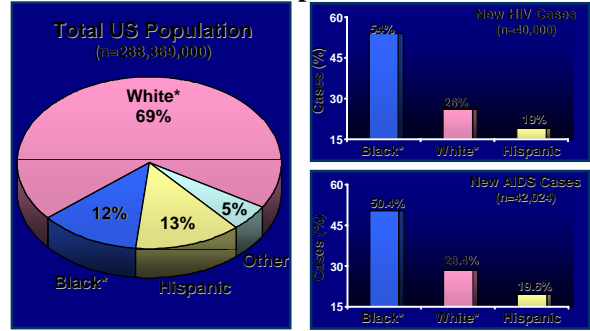
Coercive Shortcut

## Social/Ethical

- **Ignoring** stigma is not the same as **addressing** stigma.
- **Differential application:** Funding realities mean new recommendations are more likely to be implemented in publicly funded clinics than private MDs offices.
- **“Medicalization” encourages communities’ passivity**, discourages work to impact risk behavior.
  - E.g. MSM in 1980’s

Coercive Shortcut

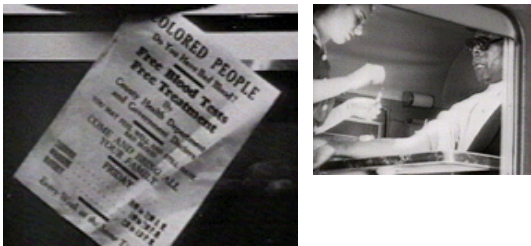
## Disproportionate Incidence of New Cases of HIV/AIDS in People of Color in 2002



CDC: HIV/AIDS Surveillance Report. 12/2003.

Coercive Shortcut

## 1972 – The Tuskegee Syphilis Experiment



Coercive Shortcut

## Community Beliefs About HIV: RAND Study

- 500 African Americans surveyed by phone
- Education:
  - High school grad or less 51%
  - Some college or more 49%
- Income:
  - <\$35,000 53.4%
  - >\$35,000 46.6%

Bogart, Thorburn (2005)

**Coercive Shortcut**

### Community Beliefs: RAND Results

- Institutions are trying to stop HIV 75.4 %
- AIDS is a form of genocide 15.2 %
- AIDS was produced in a government lab. 26.6 %
- People who take new meds are guinea pigs 43.6 %
- Cure for AIDS exists, but withheld from poor 53.4 %
- Information about AIDS is being withheld 58.8 %

Bogart, Thorburn (2005)

**Coercive Shortcut**

### Social/Ethical

- **Long term consequences** of not involving affected communities.
  - One origin of health disparities.
- “Nothing about us, without us.”

**Coercive Shortcut**

### 2005 Katrina



**Coercive Shortcut**

### Coercive Shortcut

- Reduces emphasis on prevention.
- Avoids dealing with stigma and consent complications.
- Violates principles of autonomy for pts.
- Perpetuates the paternalism of a racist medical system.

## Needed Public Health Tool



- Identify more positives.
- Bring them into care early.
- Prevent further infections.
- Reduce stigma by normalizing testing.

## Audience Vote:

**Public Health Tool  
or  
Coercive Shortcut?**