

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 3-A-10

Subject: Amendment to E-2.23, “HIV Testing”
(Resolution 517, A-09)

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Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Madelyn E. Butler, MD, Chair)

1 MANDATORY HIV TESTING DURING LABOR

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3 This report is submitted in response to Resolution 517 (A-09, HIV Testing During Labor),
4 introduced by North Carolina Delegation, which asked the American Medical Association (AMA)
5 to support state policies that seek mandatory rapid HIV testing for “all pregnant women in labor
6 with no record of an HIV test during the current pregnancy.” Because mandatory HIV testing—i.e.,
7 testing without specifically informing the patient or permitting refusal of testing—is not consistent
8 with current AMA policies, the Council on Ethical and Judicial Affairs (CEJA) was asked to
9 review the proposed policy. Based on its review of the most up-to-date epidemiologic data
10 available, with assistance from the Council on Science and Public Health, and of the ethical
11 analysis that informs current policies, CEJA concludes that there are currently no compelling
12 reasons to issue new policy specifically relating to intrapartum testing for HIV that recommends
13 mandatory HIV testing. CEJA recommends that existing House policies be reaffirmed and that
14 editorial changes as noted below be made to clarify CEJA Opinion E-2.23, “HIV Testing.”
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16 BACKGROUND

17
18 The primary goal of rapid HIV testing during labor is to identify HIV+ women whose serostatus
19 was not previously known so that appropriate interventions can be offered to reduce the risk of
20 mother-to-child transmission of HIV. Without intervention, the risk for perinatal transmission is 14
21 to 25 percent in developed countries.¹ Transmission rates vary with the prevalence of different risk
22 factors, including breastfeeding, premature birth, nutritional deficiencies, obstetrical practices, and
23 maternal viral load.² According to the most recent data available, between 100 and 200 infants are
24 infected with HIV each year in the United States, with perinatal transmission the commonest route
25 of infection.³ While it is generally believed that intrapartum vertical transmission accounts for the
26 greater number of perinatal infections,² the picture is complicated by the fact that it can be difficult
27 to determine which children acquire HIV in utero and which acquire the infection during labor and
28 delivery.⁴ Risk of intrapartum vertical transmission is also affected by whether the woman received
29 antiretroviral therapy (ART) prenatally.

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1 Prevention of mother-to-child transmission is most effective when ART is initiated during
2 pregnancy and continued through delivery for the mother and administered to the newborn after
3 birth and is the standard of care recommended by the American Academy of Pediatrics (AAP), the
4 American College of Obstetricians and Gynecologists (ACOG), and the American Academy of
5 Family Physicians (AAFP) along with scheduled cesarean delivery (when indicated) and avoidance
6 of breastfeeding.⁵⁻⁷

7
8 ART can significantly reduce HIV infection in newborns. In one population of high-risk women, a
9 three-part regimen of prenatal, intrapartum, and postnatal ART was shown to reduce mother-to-
10 child transmission from 19.4 percent to 3.3 percent.⁸ Abbreviated regimens were also found to be
11 highly effective, reducing transmission to 9.4 percent when ART was administered intrapartum and
12 postnatally (i.e., approximately 60% reduction) and to 11.9 percent when ART was administered to
13 the newborn only (50% reduction).

14
15 As Resolution 517 (A-09) notes, the main risk factor for mother-to-child transmission of HIV is the
16 pregnant women's lack of awareness of their HIV status. In the U.S., approximately 25 percent of
17 HIV+ individuals do not know their HIV status.³ Uptake of HIV testing among pregnant women
18 differs depending on the testing approach used, with "opt-in" testing proving less effective than
19 "opt-out" testing. Under the "opt-in" approach, in which the woman is provided HIV counseling
20 and must give specific consent to be tested, testing rates have ranged from 25 to 83 percent. In
21 comparison, testing rates under the opt-out approach, in which the woman is told that HIV testing
22 will be included among standard prenatal tests unless she specifically declines to be tested, have
23 ranged from 71 to 98 percent.^{1,9-11} In light of these findings, in 2006 the Centers for Disease
24 Control and Prevention (CDC) updated its guidelines to recommend routine opt-out HIV screening
25 for all pregnant women and the offer of opt-out screening with a rapid HIV test for women whose
26 status is unknown at the time of labor.¹²

27 28 CURRENT AMA POLICY

29
30 Historically, the AMA has opposed mandatory HIV testing for the general population and has
31 recognized only a very limited number of circumstances in which it may be appropriate.¹³ Current
32 House policy recommends routine, voluntary screening for all pregnant women¹⁴ and consideration
33 of rapid HIV testing of newborns with the mother's consent when maternal HIV status is not
34 known.¹⁵ While recognizing that "treatment of HIV-infected pregnant women with appropriate
35 antiretroviral therapy can reduce the risk of transmission of HIV to their infants," policy affirms
36 that "[t]he final decision about accepting HIV testing remains the responsibility of the woman."¹⁴
37 Policy similarly affirms that authority to accept or reject recommended ART for herself or her
38 infant remains with the woman.¹⁴ Existing policy further recommends that where safe alternative
39 nutrition is available, all HIV-positive women should be counseled not to breastfeed or donate
40 breast milk.¹⁶

41
42 Current ethics policy likewise provides that physicians should seek patients' informed consent
43 prior to HIV testing and should respect a patient's refusal to be tested.¹⁷ This policy parallels the
44 CDC's opt-out policy in regard to universal HIV testing. It permits nonvoluntary testing only in
45 very limited circumstances.

1 ETHICAL CONSIDERATIONS

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Decisions about HIV testing carry significant implications for core ethical values, including physicians' commitments to respect for patient autonomy and the primacy of patient well-being.¹⁸ The potential benefits of mandatory HIV testing of women in labor must be carefully balanced against the harms to such core values that could result from condoning testing without consent. Mandatory HIV testing for any targeted population, including women in labor, is ethically justifiable only when the expected benefits outweigh the anticipated harms.

9 Respect for patient autonomy is one of the cornerstones of medical ethics; it is a foundation of the patient-physician relationship and underlies physicians' ethical obligation to seek informed consent for medical interventions. Mandating HIV testing without patient consent (or informed refusal) would undermine physicians' ability to uphold this core value and is in conflict with existing policies supporting patients' rights to self-determination and voluntary consent for medical interventions.^{19,20} Moreover, to serve the intended public health goal of mandatory intrapartum testing, physicians must not simply perform HIV testing without consent or after refusal, but also be prepared to administer ART to both the woman and to the newborn against the woman's wishes.

17
18 Further, in promoting the interests of the soon-to-be-newborn over those of the woman in labor, mandatory intrapartum HIV testing would contravene physicians' duty to regard responsibility to the patient as paramount.²¹ It is not consistent with modern ethics to allow beneficence-based decision-making on the behalf of the fetus/newborn trump the autonomous decision of the pregnant woman. Physicians have a duty to minimize risks of harm to not just the fetus or newborn, but to the woman in labor as well and should appreciate the risk of social and psychological harm to the woman.²² In the U.S., misconceptions about HIV/AIDS are still widespread²³ and fear of social stigma remains a concern.^{1,24} And even if a rapid test result ultimately proves to be a false positive, the patient is likely to experience some psychological trauma.¹ This trauma may be particularly severe for women with limited income and access to health care, as is often the case among HIV-positive women.²⁵

29
30 Mandatory HIV testing also carries significant ethical implications for appropriate implementation. We concur with the observation of the (then) Council on Scientific Affairs in its 2001/2002 report on universal screening of pregnant women for HIV that identifying HIV-positive individuals also ethically requires that they be provided appropriate follow-up in medical care and social services.² The report further notes that difficult questions would arise regarding whether a individual identified as HIV-positive through mandatory screening could be forced to submit to ART, which is complex and requires active participation by patient and physician, as well as what ethical and legal consequences should follow if the individual refuses therapy. Opt-out policies are widely endorsed by key institutions, including the CDC,¹² AAFP,⁷ AAP,⁵ and ACOG.²⁷ States too have consistently supported voluntary testing, in opt-out or opt-in policies. Of the 27 states that have statutes addressing prenatal HIV testing, 19 have provisions specific to testing during labor of women with unknown or undocumented HIV status.²⁸ Of states that address intrapartum testing specifically, 16 have adopted opt-out policies, while three require that physicians offer the test and receive opt-in consent. With the exception of North Carolina, where a newly enacted statute appears to permit testing without a woman's consent, none have adopted mandatory HIV testing for women in labor.

1 CONCLUSION

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3 Given these considerations and in light of data both on the current rate of mother-to-child
4 transmission of HIV as well as the success rate of opt-out universal HIV testing, we conclude that
5 mandatory rapid HIV testing of woman in labor is a disproportionate response to the goal of
6 protecting the interests of fetuses and infants at risk for HIV infection.

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8 In CEJA's view, a more ethically appropriate approach would seek to build on the successes of opt-
9 out policies that have already achieved high screening rates. Such efforts may include enabling
10 health care professionals to proactively overcome barriers, such as differences in language,
11 misperceptions about risk status, lack of time for counseling and testing, and state regulations
12 requiring separate written informed consent.^{12,29} Other policies that increase the availability and
13 accessibility not only of HIV testing, but also of subsequent counseling and treatment may further
14 encourage women to learn their HIV status. And at an individual level, physicians should strongly
15 recommend HIV testing to all pregnant women, including those who go into labor without knowing
16 their serostatus. Studies indicate that physician encouragement has a positive influence on a
17 woman's decision to get tested.¹²

18
19 RECOMMENDATIONS

20
21 CEJA does not find that there are compelling reasons to issue new AMA policy supporting
22 mandatory rapid HIV testing for women in labor with unknown serostatus. The Council therefore
23 recommends that the following be adopted in lieu of resolution 517 (A-09), and that the remainder
24 of this report be filed.

- 25
26 1. That our AMA reaffirm Policy H-20.918, "Maternal HIV Screening and Treatment to Reduce
27 the Risk of Perinatal HIV Transmission", in lieu of Resolution 517 (A-09).
28
29 2. That Opinion E-2.23, "HIV Testing," be amended as follows:

30
31 Physicians' duties to promote patients' welfare and to improve the public's health are fostered
32 by routinely testing their adult patients for HIV. Physicians must balance these obligations with
33 their concurrent duties to their individual patients' best interest by following the guidelines
34 below:

- 35
36 (1) In order to protect patients, avoid injury to third parties, and promote public health,
37 physicians should support routine universal screening for HIV with opt-out provisions.
38 ~~Physicians should support routine HIV testing procedures in order to protect patients,~~
39 ~~avoid injury to third parties, and promote public health.~~
40
41 (2) Although~~While~~ medical and social advances may have minimized the need for specific
42 written consent prior to HIV testing, the ethical tenets of respect for autonomy and
43 informed consent require that physicians ~~should~~ continue to seek patients' informed
44 consent to undergo any form of medical treatment, including refusal of HIV testing.
45 Given the potential benefits to a patient (and the patient's intimate others) of knowing
46 his/her HIV status, it is appropriate for physicians to make efforts to persuade reluctant
47 patients to be screened. Physicians should, however, respect the decision of a patient
48 who "opts out." ~~Unless required by law, patients' consent to HIV testing does~~
49 ~~not need to be documented in writing (unless required by law), although.~~ However, the

- 1 conversation concerning testing should be documented in the patient's chart. It is
2 justifiable to test patients without prior consent only in limited cases where the harms
3 to individual autonomy are offset by significant benefits to known third parties. Such
4 exceptions include testing for the protection of occupationally-exposed health care
5 professionals or patients.
6
- 7 (3) Physicians must work to ensure that patients identified as being HIV positive receive
8 appropriate follow-up care and counseling.
9
- 10 (4) Physicians must comply with all applicable disease reporting laws while taking
11 appropriate measures to safeguard the confidentiality of patients' medical information
12 to the extent possible.
- 13 (5) Physicians must honor their obligation to promote the public's health by working to
14 prevent HIV-positive individuals from infecting third parties within the constraints of
15 the law. If an HIV-positive individual poses a significant threat of infecting an
16 identifiable third party, the physician should:
- 17 (a) notify the public health authorities, if required by law;
18
19 (b) attempt to persuade the infected patient to cease endangering the third party; and
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21 (c) if permitted by state law, notify the endangered third party without revealing the
22 identity of the source person. (I, IV, VII)
23
- 24 (Modify HOD/CEJA Policy)

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

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