Whereas, 19.3% of women and 1.7% of men in the United States report being raped during their lifetime, and 1.8 per 1000 children have been sexually abused; and

Whereas, The Centers for Disease Control and Prevention (CDC) estimates the risk of contracting HIV from a known HIV-positive person through consensual vaginal intercourse at 0.1%–0.2% and anal intercourse at 0.5%–3%, and this risk may increase during sexual assault due to injuries sustained by the individual; and

Whereas, Post-Exposure Prophylaxis (PEP) is antiretroviral medication (ART) taken within 72 hours of HIV exposure to prevent infection, and is extremely effective at preventing seroconversion after HIV exposure; and

Whereas, Current CDC guidelines indicate that persons with nonoccupational exposure to HIV should be offered PEP within 72 hours even if the HIV status of the exposer is unknown; and


Whereas, Hospital emergency departments (EDs) typically serve as the primary point of care for survivors of sexual assault, accounting for approximately 65,000–90,000 emergency department visits per year;\textsuperscript{13} and

Whereas, Only 14.5% of assault survivors were offered PEP, and only 8.5% of uninsured assault survivors were offered PEP in a 2009 survey of 117 Los Angeles Emergency Departments;\textsuperscript{14} and

Whereas, A 2018 meta-analysis found that the nationally pooled mean of individuals who were sexually assaulted and offered PEP at studied emergency departments was 55.9%;\textsuperscript{15} and

Whereas, There is no national consensus on emergency medicine residents' education about sexual assault examinations, which results in suboptimal care for the survivors of sexual assaults;\textsuperscript{13,16,17,18,19} and

Whereas, A qualitative study in 2016 of sexual assault patients found that physicians neglecting to offer PEP is a major barrier to patient access, disproportionately affecting those who are homeless or uninsured;\textsuperscript{11,20} and

Whereas, The same study indicated that the physicians neglected to offer PEP or they provided incorrect counseling due to a lack of knowledge about state or national PEP guidelines and a 2013 study found 20% of emergency physicians were not aware CDC PEP guidelines;\textsuperscript{20,21} and

Whereas, The cost of PEP is between $600-$1000, and persons prescribed PEP after sexual assault can be reimbursed for medications and clinical care costs through state Crime Victim’s Compensation Programs funded by the U.S. Department of Justice;\textsuperscript{22,23,24} and


\textsuperscript{17} Samantha Schilling et al., "Testing and Treatment After Adolescent Sexual Assault in Pediatric Emergency Departments.\textquotedblright; \textit{Pediatrics} 136, no. 6 (December 2015): e1495-503, doi:10.1542/peds.2015-2093.

\textsuperscript{18} Monika K Goyal et al., "Enhancing the Emergency Department Approach to Pediatric Sexual Assault Care: Implementation of a Pediatric Sexual Assault Response Team Program.\textquotedblright; \textit{Pediatric Emergency Care} 29, no. 9 (September 2013): 969–73, doi:10.1097/PEC.0b013e3182a21a0d.


\textsuperscript{21} Allan E Rodríguez et al., "HIV Medical Providers’ Perceptions of the Use of Antiretroviral Therapy as Nonoccupational Postexposure Prophylaxis in 2 Major Metropolitan Areas.\textquotedblright; \textit{Journal of Acquired Immune Deficiency Syndromes (1999)} 64 Suppl 1, no. 0 1 (November 1, 2013): S68-79, doi:10.1097/QAI.0b013e3182a901a2.


Whereas, The estimated lifetime cost for HIV treatment was $367,134 in 2009 and $379,668 in 2010, and the estimated medical cost saved by preventing one HIV infection is $229,800;\textsuperscript{25,26}

Whereas, Many living with HIV may find it challenging to perform daily tasks, participate in moderate physical activities, or have the energy to engage in an active social life;\textsuperscript{27} therefore be it

RESOLVED, That our American Medical Association advocate for education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines (New HOD Policy); and be it further

RESOLVED, That our AMA support increased public education about the effective use of Post-Exposure Prophylaxis for HIV (New HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-20.900 by addition and deletion as follows:

H-20.900, “HIV, Sexual Assault, and Violence”
Our AMA believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all victims survivors of sexual assault, that these victims survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained. (Modify Current HOD Policy)

Fiscal Note: not yet determined

Date Received: 09/21/18

RELEVANT AMA POLICY:

E-8.1 Routine Universal Screening for HIV
Physicians primary ethical obligation is to their individual patients. However, physicians also have a long-recognized responsibility to participate in activities to protect and promote the health of the public. Routine universal screening of adult patients for HIV helps promote the welfare of individual patients, avoid injury to third parties, and protect public health. Medical and social advances have enhanced the benefits of knowing ones HIV status and at the same time have minimized the need for specific written informed consent prior to HIV testing. Nonetheless, the ethical tenets of respect for autonomy and informed consent require that physicians continue to seek patients informed consent, including informed refusal of HIV testing. To protect the welfare and interests of individual patients and fulfill their public health obligations in the context of HIV, physicians should:

(a) Support routine, universal screening of adult patients for HIV with opt-out provisions.
(b) Make efforts to persuade reluctant patients to be screened, including explaining potential benefits to the patient and to the patients close contacts.
(c) Continue to uphold respect for autonomy by respecting a patients informed decision to opt out.
(d) Test patients without prior consent only in limited cases in which the harms to individual autonomy are offset by significant benefits to known third parties, such as testing to protect occupationally exposed health care professionals or patients.
(e) Work to ensure that patients who are identified as HIV positive receive appropriate follow-up care and counseling.
(f) Attempt to persuade that patients who are identified as HIV positive to cease endangering others.

\textsuperscript{26} Bruce R Schackman et al., “The Lifetime Medical Cost Savings from Preventing HIV in the United States .,” Medical Care 53, no. 4 (April 2015): 293–301, doi:10.1097/MLR.0000000000000308.
(g) Be aware of and adhere to state and local guidelines regarding public health reporting and disclosure of HIV status when a patient who is identified as HIV positive poses significant risk of infecting an identifiable third party. The doctor may, if permitted, notify the endangered third party without revealing the identity of the source person.

(h) Safeguard the confidentiality of patient information to the greatest extent possible when required to report HIV status.

AMA Principles of Medical Ethics: I, VI, VII
Issued: 2016

Sexual Assault Survivor Services H-80.998
Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.
Citation: Res. 56, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: Res. 202, I-17

HIV, Sexual Assault, and Violence H-20.900
Our AMA believes that HIV testing should be offered to all victims of sexual assault, that these victims should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained.
Citation: (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)

Access to Emergency Contraception H-75.985
It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians’ offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter.
Citation: (CMS Rep. 1, I-00; Appended: Res. 408, A-02; Modified: Res. 443, A-04; Reaffirmed: CSAPH Rep. 1, A-14)

HIV Postexposure Prophylaxis for Medical Students During Electives Abroad D-295.970
Our AMA: (1) recommends that US medical schools ensure that medical students who engage in clinical rotations abroad have immediate access to HIV prophylaxis; and (2) encourages medical schools to provide information to medical students regarding the potential health risks of completing a medical rotation abroad, and on the appropriate precautions to take to minimize such risks.
Citation: (Res. 303, A-02; Reaffirmed: CCB/CLRDP Rep. 4, A-12)

Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895
1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.
Citation: Res. 106, A-16; Modified: Res. 916, I-16; Appended: Res. 101, A-17