Ethics Seminars: HIV Testing, Consent, and Physician Responsibilities

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Abstract. Emergency physicians constantly have multiple ethical obligations in the emergency department. They must understand these sometimes conflicting obligations and learn to prioritize. A case discussion is presented that exemplifies the conflict between patient privacy and society's right to know. Specific aspects of HIV testing and obtaining patient consent are presented. Teaching physicians are encouraged to use such common cases for "ethics case discussion." **Key words:** HIV; consent; ethics. ACADEMIC EMERGENCY MEDICINE 2001; 8:1197–1199

BRIEF CASE PRESENTATION

A 34-year-old male presented to the emergency department (ED) complaining of seven to 12 loose, watery stools daily for the past three months. He described associated fever, chills, abdominal cramps, fatigue, and dyspnea. He had no significant past medical history, but did report previous intravenous (IV) drug use and a history of unprotected homosexual activities from 1993 to 1998 while incarcerated. He also had multiple unprotected sexual encounters with prostitutes. Currently, he is married and has a 1-year-old child. He and his wife do not use barrier protection. Physical exam was significant for oral candidiasis, but otherwise was unremarkable. Diagnostic studies were ordered, including an HIV test with verbal consent obtained.

While awaiting study results, the physician approached the patient to discuss physician concerns about possible diagnoses. The patient became defensive when the physician mentioned HIV and the patient stated he did not want the test done. The patient then said he had "business" to attend to and abruptly left the ED. An order was placed in the medical record to cancel the HIV test. The next day a positive HIV test was reported by the hospital lab.

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ETHICAL DILEMMAS—AUTONOMY

Right to Know. This short encounter provides the physician with multiple areas of ethical decision making. Most Western European and North American social and medical systems operate under the primary ethical principle of *autonomy*. This principle allows the individual to determine the degree to which he or she will participate, or not, in any specific activity, including health care. For the patient to exercise autonomy, he or she must have a degree of understanding of his or her choices. Hence, medical providers have a subsidiary "duty to inform" the patient about possible diagnoses and obtain informed consent for performance of indicated tests.[1,2] This allows the patient to consider a risk/benefit ratio meaningful to him or her.

During this decision-making process, some patients concentrate on the pain of phlebotomy, while others fear the mere mention of HIV or AIDS. At times patients attempt to have the physician make the decision for them. Rather than simply imposing the physician's own choices on the patient, the ethical physician should engage in further discussion to assess the patient's underlying lifestyle choices and situation.[1] Knowledge of the patient's views of risk taking, value of the present vs. the future, and other data can be used to help guide the patient to see which choice is best suited to him or her; or at least have a more profound understanding of the choices presented to him or her.

Right Not to Know. As a general principle of medicine, physicians are obligated to discuss all diagnostic and therapeutic interventions with patients. In addition, the physician must decide when to accept implied consent and when full documented consent is required.[3] In many cases this educational discussion does not occur, or is very superficial for low-risk diagnostic tests.

When obtaining informed consent from patients, the emergency physician must consider the patient's competence level. Certain patients may be competent to make simple decisions, but not competent to make decisions on more complex issues. At the time of decision the physician must determine the patient's level of competence for each particular issue. Simple tests of competence generally involve no more than the presentation of facts, and then asking the patient to repeat back the salient points.

Usually interventions requiring consent carry some risk of adverse outcome, or involve end-of-life issues. The risks of having an HIV test performed are of a far different variety.[2] There is essentially no risk medically to the patient in obtaining the blood sample to perform the test; and the objective medical benefits of knowing one's HIV status are documented.[4] The risks to the patient of a positive HIV test are of a social and psychological nature. A positive HIV test can lead to loss of support from family or friends, depression, broken relationships, and myriad other problems that could have a tremendous impact on the patient's personal life. Cases have been documented of patients' being attacked and injured or killed when their illness was revealed.[5–7]

For many years employment could be threatened if a person was thought to have AIDS.[2] As a result, HIV tests have been given a special status that is not afforded other basic medical tests in our country. Over the last several years, the prejudices previously associated with HIV have become far less common. However, when asking a patient to consent to an HIV test, any number of idiosyncratic reasons to accept or to refuse may surface in the patient's mind. Possibly the patient has never thought about the issue or perhaps is reminded of a friend who committed suicide or otherwise suffered discrimination after being diagnosed as having AIDS. It is doubtful that we often know the true reason for a patient's refusal to accept an HIV test.

With these thoughts in mind, the physician must also face the question of doing the test in the ED. The benefit of pre- and posttest counseling in HIV is well known.[8] Some physicians believe that it is inappropriate to order HIV tests in the ED for patients who will not be admitted due to the need for this counseling, which may not be available in the ED. Having an individual's positive HIV test results with incomplete patient tracking information could make patient notification difficult or impossible. Hence, many physicians believe it is more appropriate to refer individuals not needing admission to primary care clinics, to a public health service, or to a local agency offering free, anonymous testing with counseling and follow-up. On the opposite side[9] are physicians who recognize that emergency physicians are in many cases de facto primary care providers.

Resolving the Problem

In the case presented above, the physician is faced with the obvious dilemma of what to do with this patient's positive HIV test result. Before we consider the options available to us, we must consider the context of the patient's decisions while he was in the ED. Our patient evidenced a sudden change in temperament in requesting the test not be performed. This suggests an emotionally laden, perhaps uninformed decision. It is quite possible that with further discussion the patient would better understand the importance of knowing his HIV status and be able to cope with the results appropriately. In addition, this is a test performed on his body, and is a part of his medical record. Thus, one could strongly argue that our first line of action should be to attempt to contact the patient. By doing this, patient confidentiality would be preserved and the patient would be able to digest and divulge the information as he deems necessary, thus maintaining his autonomy.

Unfortunately, the above case was not so simple. We were unable to locate our patient and had no idea of his whereabouts or current activities. We did not have the luxury of time as it was possible that he was currently placing others at risk of contracting HIV. In this situation many physicians believe the principle of beneficence overrides patient autonomy. The patient's wife and child might be infected, and further delay of potential HIV diagnosis and treatment increases their risk of complications.[10,11] In this situation one would ordinarily proceed to inform an at-risk third party. There is legal basis that physicians have an obligation to inform such parties.[12,13]

Our third option in this case is to ignore the test results. If the physician orders had been properly followed, this test never would have been performed. Thus, a busy physician could rationalize that the test results should be discarded as if they were never obtained. Most physicians would probably disagree with this approach, realizing that it is in the patient's (as well as the family's) best interest to know this information regardless how it was obtained.

Finally, emergency physicians need to be up to date with state and local reporting obligations for various infections. Even if the physician has decided not to attempt to contact the patient or his family with the results, one would still be required to inform the proper health authority in most jurisdictions.[2]

CONCLUSIONS

Our patient did return to the ED nearly one month after his initial visit. He had received the letter sent to him by the ED and had it with him. He was in a much deteriorated condition and was admitted to the internal medicine service.

This provocative case presents an uncommon combination of common ethical issues. The conflicts between autonomy and beneficence will be faced by each of us during our careers. As educators and providers in emergency medicine, we must remain vigilant about recognizing cases such as this during our daily practice. This will allow us opportunities to sharpen our ethical acumen, as well as allowing us to capitalize on patient care dilemmas for student/resident education on ethical issues in emergency medicine. In our residency program we were able to use this case during a case conference discussion where it served as a valuable springboard into significant ethical debate. The more time we spend personally considering, and ensuring that our residents and students consider, such ethical dilemmas, the more skilled we will be at handling these issues in clinical practice.

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Poems and short stories must have a title and body. Two hard copies and one electronic copy should accompany each submission. A cover letter should identify the submission as *Reflections*. Photographs should have a title and may have a caption of no more than 50 words. All submissions must be accompanied by a signed copyright release and author disclosure form.

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