
The Need For New Guidelines For AIDS Testing & Counseling: An Ethical Analysis

P Clark

Citation

P Clark. *The Need For New Guidelines For AIDS Testing & Counseling: An Ethical Analysis*. The Internet Journal of Infectious Diseases. 2005 Volume 5 Number 2.

Abstract

The Centers for Disease Control and Prevention (CDC) has estimated that approximately 40,000 persons become infected with HIV each year. Despite widely available testing and medications it is estimated that a quarter of Americans infected with HIV are unaware of their status. The result is that these individuals are continuing to spread this lethal infection unknowingly and are failing to obtain the powerful drug therapies that have been proven to extend their lives. One of the major obstacles standing in the way of many individuals knowing their HIV status are the current "HIV Counseling, Testing, and Referral Guidelines" issued by the CDC which emphasize that HIV testing be informed, voluntary, and consented and available as confidential and anonymous services and that mandatory counseling be "client-centered." This strategy may have been necessary in the late 1980s and the early 1990s when there was no effective treatment for AIDS and the disease was associated with gay men who were already facing discrimination, but today it is having a negative impact.

The revision of the CDC guidelines on HIV testing and counseling are medically necessary and ethically justified. In the 25 years since the advent of AIDS, medical advances have made this once lethal disease a manageable condition for many individuals. Legal safeguards are in place to protect the basic rights of privacy and confidentiality of HIV infected persons. And ethical principles have been used to justify changes that have been proposed in our thinking about the management and treatment of this disease. Streamlining the present CDC guidelines by making testing a routine part of medical care, simplifying the process by which a person consents to be tested and shortening and simplifying the counseling that takes place before a person is tested will help HIV-infected person to get the needed medical care before they are already sick with AIDS, will save others from being infected unknowingly, and will utilize our limited medical resources in a way that maximizes their benefits for society as a whole. These proposed changes are not only medically necessary; they are ethically imperative.

INTRODUCTION

On May 30, 2006 the United Nations AIDS program issued the results of a study called "Report on the Global AIDS Epidemic: A UNAIDS 10th Anniversary Special Edition," suggesting that the global AIDS pandemic has begun to slow, with a decline in new HIV infections in about 10 countries. Despite these findings AIDS is a very complex epidemic and despite these positive trends Dr. Peter Piot, Executive Director of UNAIDS reported grim findings from China, Indonesia, Papua New Guinea, Russia and Vietnam, with signs of outbreaks in Bangladesh and Pakistan. ¹ If this trend is to continue, Thoraya Ahmed Obaid, executive director of the United Nations Population Fund, said that the world needed to increase its prevention efforts. ² One example that was cited in the UN report was the experience in Botswana where the government recommended in 2004

that diagnostic HIV testing become a routine part of medical check-ups. UNAIDS recommends offering the tests in clinics treating sexually transmitted infections, maternal health clinics, and at community-based health service settings where there is access to antiretroviral drugs. ³ Widespread, aggressive testing is one of the keys to early detection and preventing the further spread of AIDS.

In the United States, as of 2003, an estimated 1,039,000 to 1,185,000 persons were living with HIV/AIDS. "In 2004, 38,730 cases of HIV/AIDS were diagnosed in the 35 areas (33 states, Guam and the U. S. Virgin islands) with long-term, confidential name-based HIV reporting. The Centers for Disease Control and Prevention (CDC) has estimated that approximately 40,000 persons become infected with HIV each year." ⁴ Despite widely available testing and medications it is estimated that a quarter of Americans

infected with HIV are unaware of their status. The result is that these individuals are continuing to spread this lethal infection unknowingly and are failing to obtain the powerful drug therapies that have been proven to extend their lives.⁵ One of the major obstacles standing in the way of many individuals knowing their HIV status are the current “HIV Counseling, Testing, and Referral Guidelines” issued by the CDC which emphasize that HIV testing be informed, voluntary, and consented and available as confidential and anonymous services and that mandatory counseling be “client-centered.”⁶ This strategy may have been necessary in the late 1980s and the early 1990s when there was no effective treatment for AIDS and the disease was associated with gay men who were already facing discrimination, but today it is having a negative impact. A number of studies have recommended routine HIV testing of all American adults;⁷ New York City's Health Commissioner, Dr. Thomas Freidman, has called for changing New York state laws so that health officials could more aggressively test people for HIV and AIDS and use the medical information the city already collects to help treat those infected;⁸ California presently does not require separate written consent for HIV testing;⁹ and as of May 16, 2006, San Francisco's city-run medical clinics will no longer require written consent and counseling sessions before testing people for HIV in order to increase the number of people screened for the virus.¹⁰ These new initiatives have challenged the CDC and AIDS advocates to rethink their position on testing and counseling. As a result, hopefully the CDC will offer new guidelines for AIDS testing and counseling in the summer of 2006. These guidelines are not only overdue, they are an ethical necessity.

The purpose of this article is twofold: first, to present solid reasons why there should be new guidelines for AIDS testing and counseling; and second, to give an ethical justification for these new guidelines.

NEED FOR NEW GUIDELINES

On the 25th anniversary of the detection of AIDS it is estimated that over a million people in the United States are living with HIV/AIDS. As of 2004 over half the estimated number of new HIV/AIDS cases diagnosed (51%) were among African Americans--up from 25% in 1985—and account for 55% of people dying nationally of AIDS, although they make-up approximately 13% of the U. S. population.¹¹ With the advent of new medications, like the protease inhibitors, there has been a dramatic decrease in AIDS deaths--8%. However, the number of AIDS diagnoses

has increased 8% during the same period. Better treatments have also led to an increase in the number of persons in the United States living with HIV/AIDS. From 2000 through 2004, the estimated number of persons in the United States living with AIDS increased from 320,177 to 415,193—an increase of 30%.¹² The death rates are falling but the number of people living with the HIV infection continues to rise, especially in the minority communities. One problem is that as new antiretroviral medications and treatments become available HIV has moved from being a death warrant to becoming a more manageable condition, at least for those who can afford the expensive medications. The problem is that a sense of complacency has set-in among some and this complacency is causing more infections and even deaths. The major issue is still a lack of accurate information and an increase in misinformation about HIV/AIDS. The current status of HIV/AIDS in the U.S. could be detailed as follows: “The risk of death from AIDS: way down. Risk of death from other things: going up. Risk of drug reaction: depends. Risk of fatal drug reaction: low but not zero. Risk of drug resistance: gets higher every year. The statistics change almost hourly as treatments appear.”¹³ Yes, new medications have turned AIDS into a chronic, manageable disease for many in the United States, but what is rarely discussed are the side-effects of these medications, their failures, and the cost and increased burden this disease is having on our health care system.

Twenty-five years ago when AIDS was first detected and during the early 1990s there were major concerns regarding patient confidentiality in order to protect HIV/AIDS patients from discrimination. In the early years of AIDS, and still to some extent today, discrimination toward HIV/AIDS patients was a major concern. The stigma of AIDS and the fear that surrounded this disease caused irrational behaviors among many in society. In order to protect the basic rights of privacy and confidentiality of AIDS patients various stringent laws were enacted both federally and on a state-by-state basis. On the federal level, the “Americans With Disabilities Act” has been used to defend the rights of HIV/AIDS patients against various forms of discrimination.¹⁴ On the state level, various laws exist to protect the rights of HIV/AIDS patients. One example is Pennsylvania's--Act No. 148--”AIDS—Confidentiality of HIV-Related Information Act,” passed in 1990, which had the intention “to promote confidential testing on an informed and voluntary basis in order to encourage those most in need to obtain testing and appropriate counseling.”¹⁵ The intention of the Pennsylvania Legislature was to protect patient

confidentiality against discrimination by stating clearly that “no HIV test shall be performed without first obtaining the informed written consent of the subject. Any consent shall be preceded by an explanation of the test, including the purpose, potential uses, limitations and the meaning of its results.”¹⁶ In addition, “no positive or negative test results shall be revealed to the subject without affording the subject the immediate opportunity for individual, face-to-face counseling...”¹⁷ The stipulations of this law do protect HIV/AIDS patients from discrimination but do not encourage aggressive testing, so therefore, many people who are unaware of their HIV status, will not receive the needed medication that could save their lives, and they may continue to infect others unknowingly. In 2001 the CDC revised its guidelines for “HIV Counseling and Testing and Referrals.”

The goals of the new guidelines are to ensure that persons with HIV infection and persons with increased risk receive high quality HIV prevention counseling to reduce their risk of transmitting or acquiring HIV; have early knowledge of their HIV status; and have access to appropriate services. The guidelines also promote early knowledge of HIV status through HIV testing and ensure that all persons recommended or requesting HIV test services receive information about HIV transmission and prevention, as well as HIV test specifics. The new guidelines still recommend that HIV testing should be informed, voluntary, and consented and available as confidential and anonymous testing services...¹⁸

The American Medical Association's guidelines for HIV testing echo the CDC's guidelines.

Physicians should ensure the patient's informed consent specific for HIV testing before testing is performed. . . Consent for HIV testing cannot be inferred from a general consent to treatment. . . The confidentiality of the results of HIV testing must be maintained as much as possible and the limits of a patient's confidentiality should be known to the patient before consent is given. . . In order to limit the public spread of HIV infection, physicians should encourage voluntary testing of patients at risk for the infection.¹⁹

Privacy and confidentiality are basic rights and we need to be concerned that these rights are protected. However, in this day and age when HIV/AIDS has become more of a chronic, manageable disease, and the stigmatization of HIV has lessened, and the issues of privacy and confidentiality are being protected, for the most part, by state and federal laws, it is time to support a move to streamline the testing and

counseling process. Privacy and confidentiality are basic rights that must be protected but so is the right to life.

Advocates of streamlining the HIV testing and counseling process believe that the CDC should address three obstacles to treatment. First, health care providers should shorten and simplify the counseling session before the patient is tested. Second, new guidelines should be implemented that allow patients to give oral consent to testing, rather than the written consent form. Third, health care providers should incorporate HIV testing as a routine part of care in the traditional medical settings. It appears that the CDC will issue new guidelines to deal with these obstacles in the summer of 2006. The proposed recommendations will address the testing regimen, suggesting that physicians not only test people at risk, but as part of routine medical care for all patients ages 13 to 64.²⁰ The impetus for this change may be the success that Botswana has had using this method. Botswana, one of the world's most infected countries, made HIV testing a regular part of blood tests conducted in government health facilities for medical purposes. Such tests are routine but not compulsory. All citizens will be tested unless an individual “opts-out” of the testing. An estimate is up to 35% of the country's 1.7 million people now know their HIV status and the infection rate is declining.²¹

In April 2003, federal health officials recommended that pregnant women, intravenous drug users and anyone who has engaged in unsafe sex be routinely screened for HIV. In addition, a study in the March 2006 edition of *Pediatrics* underscores the concern about the low rate of HIV testing among at-risk adolescents. The result is that there are numerous infected adolescents who are unaware of their status and not receiving care. The study confirms that one-fifth of the youth studied were identified as HIV+ within six months of seroconversion, which indicates that someone (the adolescent or a health provider) recognized the potential HIV infection, based on symptoms and/or perceived risks. The authors believe that early and repeated testing in adolescents at risk for HIV would avoid delays in specialized HIV care.²²

Advocates of routine HIV testing and new CDC guidelines to simplify counseling sessions and allow for oral consent to HIV testing are being motivated by two factors. First, HIV infection in the United States is usually discovered at an advanced stage and usually in the course of medical care and often from complications of AIDS. Earlier diagnosis would speed access to appropriate care, increase the proportion of

HIV-infected patients receiving care which would improve their quality of care, and potentially save others from becoming infected.²³ The advancement of Rapid HIV tests such as the OraQuick Advanced Rapid HIV Antibody Test has revolutionized efforts aimed at slowing the spread of this infection. This HIV-1 antibody test offers results that are 99.6% accurate and the results can be determined within 20-30 minutes. If the result of the test is positive, it is still preliminary until a confirmatory test is conducted. While there is a high probability that the individual is infected with HIV, it is still necessary to have a confirmatory test to be certain. The rapid test can be conducted either through a mouth swab or finger prick and the mechanism used could vary from test site to test site. The rapid test is revolutionary because the older ELISA test required about one week for confirmation and about one third (32%) of people tested at HIV clinics never returned to pick-up their results. This means that those who never learned that they tested positive most likely went on to infect others through unprotected sex or by sharing needles as intravenous drug users.

The problem is that the rapid tests like the traditional blood tests, cannot detect the first phase of HIV infection. These tests do not look for the virus itself but rather for antibodies that the immune system makes to fight the infection. It takes time for the body to produce enough antibodies to be detectable. The rapid test will get results to the individual within 20 minutes which should eliminate those individuals who never returned for their test results. However, the rapid test still does not detect the earliest stage of infection. There is a solution to this problem. The partial solution is to test for the RNA of the virus itself, which can be detected within 10 days of infection. Blood banks have used this test for a decade.²⁴ The problem is that the test is expensive.

Instead of a test on each blood sample, the samples are combined into pools of 10 to 100. Most pools test negative, meaning that all samples in the pool are negative. If a pool tests positive, it is broken down into smaller groups and retested until the infected sample is found. Like conventional antibody testing, RNA testing takes several days. North Carolina adopted this technique in 2003 for all publicly financed testing. San Francisco also made RNA testing standard in its sexually transmitted disease clinic in 2003, but uses rapid antibody tests in other settings. . . In North Carolina, 4% of the infections found by RNA tests are not detected by antibody tests. In San Francisco the figure is 10%. The cost of RNA testing in North Carolina has worked out to \$3.63 per person tested. But in San Francisco, where

more tests are needed because there are more HIV-positive results, RNA testing costs around \$30 per person.²⁵

With both tests the individual is identified early and can then begin treatment which can save his/her life and make the individual aware of his/her HIV status and thus protect others from being infected. A combination of both tests depending on the individual might not only save lives but be cost effective. In addition to advocating for use of rapid testing without written consent, Dr. Frieden, New York City Health Commissioner, is also proposing that “public health authorities could then share information about matters such as viral load and drug resistance with the HIV patient's doctor—information which can help doctors treat their patients effectively.”²⁶ Both measures would help HIV-infected patients and help to stop the transmission of HIV to others.

Second, two studies have found that the cost of routinely testing nearly all adults would be outweighed by a reduction in new infections and the opportunity to start patients on drug regimens early. Both studies confirm that widespread routine screening would not only benefit the HIV-infected person but would also be cost effective. Paltiel and colleagues estimate that “with one-time screening the mean CD4 cell count at detection was 210 rather than 154 per cubic millimeter. When repeated testing was introduced, further gains were observed especially among incident cases. For example, expanding from a single test to screening every five years raised the CD4 counts at detection among incident cases from 347 to 397 per cubic millimeter and reduced from 27% to 16% the proportion of cases that were not detected until the patient presented with an opportunistic infection.”²⁷ This is significant “because earlier access to antiretroviral therapy is likely to make it easier to suppress viral replication, improve immunity, and reduce drug-related adverse effects. It would also extend survival by 1.5 years for the average HIV infected person.”²⁸ Both studies also show the cost effectiveness of routine screening. Sanders et al. estimate the cost of one time screening to be \$41,736²⁹ whereas Paltiel et al. estimate the cost to be \$38,000 per quality-adjusted life year gained.³⁰

Both estimates are less than the commonly cited threshold for the cost-effective care of \$50,000 per quality-adjusted life-year gained. Cost effectiveness changes with the prevalence of disease. Paltiel and colleagues estimate in high-risk populations (those with 3% prevalence of HIV infection), the costs would decrease to \$38,000 per quality-

adjusted life-year gained, and the general U.S. population (which has a 0.1% prevalence of HIV infection), the costs would increase to \$113,000 per quality-adjusted life-year gained. Repeated testing decreases efficiency, since it detects only incident cases. Given a 3% prevalence of HIV infection, Paltiel et al. estimate that testing every five years would cost \$50,000 per quality-adjusted year-life gained, and testing every three years would cost \$63,000 per quality-adjusted life-year gained. Overall, these results indicate that widespread use of HIV screening is consistent with commonly accepted standards for clinical practice when the prevalence of HIV infection is 1% or higher and that testing at five-year intervals may be a reasonable approach in some populations.³¹

Both studies indicate that routine, voluntary screening for HIV once every three to five years is justified clinically and economically. In addition, besides benefiting the individual HIV infected person, such screening will help reduce the transmission of HIV to others, improve allocation of resources to treat and prevent HIV, and reduce productivity lost as a result of HIV infection.³² Bozzette also brings up a negative effect of such screening being the amount of time the clinical staff will have to give to the needed counseling of each patient. If the CDC also changes its guidelines on counseling this objection could be eliminated. Overall, the implementation of HIV screening as a routine part of care in traditional medical settings benefits those who are unaware of their HIV infection, protects those who might be at risk for infection, and benefits the nation by helping to control medical costs and fairly allocate resources.

Despite the positive aspects of advocating for a change in the CDC's guidelines for Counseling, Testing and Referral there are those who raise serious negative implications. Many AIDS activists are critical of such changes because they fear the potential abuses that may result regarding patient privacy and confidentiality. How do we ensure that those who test HIV+ will not be criminalized in an effort to contain the epidemic? Can we assure that all HIV patient's records will be kept confidential? Could individuals be tricked into being tested and thus expose them to discrimination? Over the years, health authorities have proven that they can be trusted with maintaining confidentiality but there is still much suspicion of the medical establishment especially among people of color in the United States. This is an important issue because HIV infections are the highest among people of color and those who are economically disadvantaged, because of their reduced access to health care. Second, there

is the fear among critics that minimizing or eliminating the counseling component might reduce the number of people who test positive to seek treatment. These are very legitimate concerns. The question that remains is whether there is a proportionate reason for revising the guidelines on testing and counseling?

ETHICAL ANALYSIS

Society, in general, has always recognized that in our complex world there is the possibility that we may be faced with a situation which has two consequences; one good and the other evil. The time-honored ethical principle that has been applied to these situations is called the principle of double effect. As the name itself implies, the human action has two distinct effects. One effect is intended and good; the other is unintended and evil. As an ethical principle, it was never intended to be an inflexible rule or a mathematical formula, but rather it is to be used as an efficient guide to prudent moral judgment in solving difficult moral dilemmas.

³³ The principle of double effect specifies four conditions which must be fulfilled for an action with both a good and an evil effect to be ethically justified:

1. The action, considered by itself and independently of its effects, must not be morally evil. The object of the action must be good or indifferent.
2. The evil effect must not be the means of producing the good effect.
3. The evil effect is sincerely not intended, but merely tolerated.
4. There must be a proportionate reason for performing the action, in spite of the evil consequence.³⁴

The principle of double effect is applicable to the issue of new guidelines for HIV testing and counseling because it has two effects, one good and the other evil. The good effect is that individuals will become aware of their HIV status and if positive can begin drug therapies to extend their lives, reduce the transmission of HIV to others and improve the allocation of resources to treat and prevent HIV. The negative effect is that there is the fear that such changes could lead to abuses in patient privacy and confidentiality. Ultimately, for bioethicists, it is the judgment of proportionality that is indispensable to the application of this principle. Showing that the harm caused is an indirect side effect, rather than a direct and intended effect, is not

sufficient to justify the action. The agent is still morally responsible for the foreseen, even though not intended, side effects that are avoidable because the agent could have acted differently. The various effects must therefore be balanced to determine whether the action is justified. To determine if revising the guidelines for AIDS testing and counseling is ethical, this issue will be examined in light of the four conditions of the principle of double effect.

The first condition allows for the revision of HIV testing and counseling guidelines because the object of the action, in and of itself, is good. The moral object is the precise good that is freely willed in this action. The moral object of this action is to make as many people as possible aware of their HIV status so that they can begin the drug regimen necessary to extend their lives, protect them from diseases to which HIV makes them prone, and to help reduce the transmission of HIV to others. The immediate goal is not to trick people into being tested or expose them to any form of discrimination. Rather, the direct goal is to prolong the lives of those who are HIV+ and to prevent the transmission of this lethal disease to others unknowingly. The second condition appears to allow for a revision of the CDC guidelines because the good effect of getting people into treatment early and thus extending their lives is not produced by means of the evil effect. Widespread routine testing would benefit patients who tests positive for HIV by getting them into treatment early, suppressing viral replication, improving their immune system and reducing drug-related adverse effects. It would also benefit society as a whole by reducing the transmission of HIV to others unknowingly and as both Paltiel et al. and Sander et al. have shown it is cost effective. This can only benefit our strained health care system. The potential for evil such as discrimination and deception are present. In a 2005 study, 26% of HIV-infected adults receiving health care reported experiencing at least 1 of 4 types of perceived discrimination by a health care provider since becoming infected with HIV, including 8% who had been refused a service.³⁵ This proves that the potential for abuse is real. If patients are being discriminated against by health care professionals, who are knowledgeable about HIV/AIDS, then discrimination in the general population, is a matter of concern. There are those who argue that HIV/AIDS is like every other disease—like cancer or diabetes. This is blatantly false. Getting a positive test result is something that turns somebody's life upside down.³⁶ Various forms of discrimination--jobs, health care, housing, etc.-- have occurred and most likely will continue to occur and this can cause HIV/AIDS patients to avoid testing and

ignore treatment recommendations. What has to be done is to address these examples of discrimination and put in place further safeguards to prevent them from happening in the future. Despite the potential for abuse, it is clear that the good effect is not produced by means of the evil effect, therefore, the second condition allows for the needed revisions. The third condition is intricately tied to the second condition. The direct intention of the revision of guidelines for testing and counseling is to assist those who are HIV+ to get the necessary medications in order to extend their lives. It is also to protect others from being infected with this lethal virus unknowingly, and to protect society as a whole in regards to the drain HIV/AIDS has been and will continue to be on our health care system and economy. Various studies have shown that the earlier an HIV+ person starts treatment the better chance he/she has in extending his/her life. Studies by Paltiel et al. and Sanders et al. have shown that “given the availability of effective therapy and preventive measures, it is possible to improve care and perhaps influence the course of the epidemic through widespread, effective, cost-effective screening.”³⁷ According to Bozzette, “secondary benefits to screening are that preservation of health and reductions in transmissions will also reduce work productivity lost as a result of HIV infection. These averted loses represent savings that, from society's perspective, can partially cancel out the direct expenditures. Because the indirect costs of HIV infection are substantial, the true economic costs of screening are far lower than reflected by direct expenditure.”

³⁸ The direct intention of the revising of the testing and counseling guidelines will be to benefit not only the patient but others and society as a whole. Finally, the argument for the ethical justification for revising the guidelines on testing and counseling by the principle of double effect focuses on whether there is a proportionately grave reason for allowing the foreseen but unintended possibility of abuses to individual's privacy and confidentiality. To make this determination the probability and magnitude of the good (intended) effects will have to be balanced against the probability and magnitude of the bad (side) effects in order to determine if there is a proportionate reason for allowing for the revision of the CDC guidelines for testing and counseling. Proportionate reason is the linchpin that holds this complex moral principle together.

Proportionate reason refers to a specific value and its relation to all elements (including premoral evils) in the action.³⁹ The specific value in allowing for a revision of the CDC guidelines for testing and counseling is to benefit clinically the infected person, reduce transmission of HIV to

others and improve allocation of resources to treat and prevent HIV. The pre-moral evil, which may come about by trying to achieve this value, is that HIV/AIDS still carries so much stigma that there still remains the possibility of abuses to the infected person's privacy and confidentiality.⁴⁰ The ethical question is whether the value of revising the present guidelines outweigh the pre-moral evil of the foreseen but unintended possibility that such revisions may cause potential abuses to those infected and even lead to deceiving individuals to be tested to contain the epidemic? To determine if a proper relationship exists between the specific value and the other elements of the act, ethicist Richard McCormick, S.J. proposes three criteria for the establishment of proportionate reason:

1. The means used will not cause more harm than necessary to achieve the value.
2. No less harmful way exists to protect the value.
3. The means used to achieve the value will not undermine it.⁴¹

The application of McCormick's criteria to the revision of the CDC's testing and counseling guidelines supports the argument that there is a proportionate reason for allowing for the revision of the CDC guidelines if certain safeguards are added. First, the revision of the testing and counseling guidelines will increase the number of people who will become aware of their HIV status. This will help those who are infected to receive the necessary treatment to prolong their lives, it will reduce the transmission of HIV to others and will improve the allocation of resources to treat and prevent HIV in the United States. There is the possibility that abuses and stigmatization may occur to infected individuals' privacy and confidentiality but the federal and state laws that are in place should lessen the chances of this type of abuse. Stigmas have been associated with numerous diseases—tuberculosis, syphilis, gonorrhoea, etc. “The way to address stigma is to make testing routine and integrate it across the board.”⁴² Second, at present, the CDC guidelines for HIV testing and counseling recommend that HIV testing be informed, voluntary and consented and available as confidential and anonymous testing services and that there be mandatory counseling sessions before the testing. Despite widely available testing we estimate that a quarter of Americans infected with HIV are still unaware of their HIV status. Delays in diagnosis are putting lives at risk for those who are infected and are increasing the transmission of HIV

unknowingly to others. According to Dr. Thomas Frieden, New York City's Health Commissioner, “in 2004 there were 1,038 patients who first learned they had HIV when they were already sick with AIDS. That's a damning indictment of our system.”⁴³ Early testing and diagnosis would save both lives and resources. In addition, to allow individuals to be infected by HIV unknowingly, especially those in minority communities is an evil. Statistics show that new infections continue to occur at troubling rates among the minority communities. From the beginning of this epidemic, African Americans have tested positive for HIV at a disproportionate rate. The high poverty rate among African Americans and other minority communities contributes to this disparity, because poor people have less access to medical information, preventive health care and treatment. Higher rates of sexually transmitted diseases also contribute because a person with genital lesions, for example, is more likely to contract HIV and a person carrying another disease in addition to HIV is more likely to transmit HIV.⁴⁴ Today African American men with HIV are six times as likely to die from AIDS as white men, and African American women are nine times as likely to die as white women. This disparity reflects how we have failed to keep pace with the changing nature of this epidemic.⁴⁵ At present, voluntary, consented testing is a viable option but it is not working. Allowing for verbal consent and eliminating the need for physicians to give detailed reasons why a patient may not want to be tested would save lives in the long run. By streamlining the testing and counseling guidelines and incorporating HIV testing as a routine part of care in the traditional medical settings, will allow individuals to have earlier access to antiretroviral therapy which will suppress viral replication, improve immunity and reduce drug-related adverse effects. With the proper safeguards to protect privacy and confidentiality, revision of the CDC guidelines for testing and counseling would not only save lives but would benefit society as a whole by utilizing our medical resources responsibly, which in turn will save other lives. Third, the value of clinically benefiting the infected person, reducing the transmission of HIV to others and improving the allocation of resources to treat and prevent HIV will not be undermined by revising the current guidelines on testing and counseling. The use of the Rapid AIDS test to determine one's HIV status and the new medications available to extend the lives of HIV/AIDS patients will help extend the lives of those who are infected and will protect others from becoming infected unknowingly. Laws and safeguards must be enforced to protect the privacy and confidentiality of

every HIV-infected person. The real threat to Americans is not that HIV will cause them discrimination and even stigmatization; the real threat is that HIV will kill them. Unless one is made aware of his/her HIV status early, the treat of death is imminent and the treat of harming others is inevitable. With the proper safeguards a revision of the CDC guidelines on testing and counseling would not undermine the value of human life, in the long run it would protect the value of human life.

Does the principle of double effect justify a revision of the CDC guidelines on testing and counseling? The answer is clearly "yes." With the current laws and safeguards to protect individual privacy and confidentiality and the trust demonstrated to date by medical professionals, widespread routine screening would benefit infected persons currently, would safeguard those at risk for infection and would protect the future health of our nation. The dignity and respect of all human life would be protected and the greater good would be promoted in spite of the potential for foreseen but unintended consequences.

CONCLUSION

The revision of the CDC guidelines on HIV testing and counseling are medically necessary and ethically justified. In the 25 years since the advent of AIDS, medical advances have made this once lethal disease a manageable condition for many individuals. Legal safeguards are in place to protect the basic rights of privacy and confidentiality of HIV infected persons. And ethical principles have been used to justify changes that have been proposed in our thinking about the management and treatment of this disease. Streamlining the present CDC guidelines by making testing a routine part of medical care, simplifying the process by which a person consents to be tested and shortening and simplifying the counseling that takes place before a person is tested will help HIV-infected person to get the needed medical care before they are already sick with AIDS, will save others from being infected unknowingly, and will utilize our limited medical resources in a way that maximizes their benefits for society as a whole. These proposed changes are not only medically necessary; they are ethically imperative. Failure to address these concerns places the lives of millions of human beings in our hands.

References

1. UN Centre News, "Fight Against AIDS Has Achieved Important But Even Global Progress," May 30, 2006, <http://www.un.org/apps/news/story.asp?NewsID=18671&cr=hiv&crl=aids>. See also Lawrence Altman, "Report Shows 2005 to be 'Least Bad Year' of AIDS Epidemic," New York

- Times, May 31, 2006, p. A-6.
2. Ibid.
3. Ibid.
4. Centers for Disease Control and Prevention, "A Glance at the HIV/AIDS Epidemic," April 2006. <http://www.cdc.gov/hiv/resources/factsheets/at-a-glance.htm>
5. Editorial, "New Guidelines for AIDS Testing," New York Times May 15, 2006. <http://www.nytimes.com/2006/05/15/opinion/15mon3.html?h=&emc=th&pagewanted=pri>.
6. Centers for Disease Control and Prevention, "New HIV Counseling, Testing, and Referral Guidelines: Implications and Implementation," 2001. http://www.cdc.gov/nchstp/od/program_brief_2001?new%20HIV%20Counseling%20Test.
7. G. Sanders, A. Bayoumi, V. Sundaram et al., "Cost-Effectiveness of Screening for HIV in the Era of Highly Active Antiretroviral Therapy," *New England of Medicine* 352 (6), February 10, 2005: 570-586; A. Paltiel, M. Weinstein, A. Kimmel et al., "Expanded Screening for HIV in the United States – An Analysis of Cost-Effectiveness," *New England Journal of Medicine* 352 (6), February 10, 2005, 586-596.
8. Marc Santora, "Overhaul for Laws on AIDS Tests and Data," *New York Times* February 2, 2006. <http://www.nytimes.com/2006/02/02/nyregion/02health.html?pagewanted=print>
9. Karen Matthews, "Officials, Providers at Odds on HIV Test," *Washington Post* June 4, 2006. http://www.washingtonpost.com/wp-dyn/content/article/2006/06/04/ar2006060400325_pf.
10. Paul Elias, "San Francisco Makes HIV Tests Easier," *Washington Post* May 17, 2006. http://www.washingtonpost.com/wp-dyn/content/article/2006/05/17/ar2006051702087_p.
11. Leslie Fulbright, "AIDS at 25-- Disease Denial Devastating for African Americans: Blacks Are Most Vulnerable," *San Francisco Chronicle* June 5, 2006. <http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2006/06/05/AIDSBLACK.TMP>
12. Center for Disease Control and Prevention, "A Glance at the HIV/AIDS Epidemic," April 2006. <http://www.cdc.gov/hiv/resources/factsheets/At-A-Glance.htm>
13. Abigail Zuger, "AIDS, at 25, Offers No Easy Answers," *New York Times* June 6, 2006. <http://www.nytimes.com/2006/06/06/health/06aids.html>.
14. United States Department of Justice, "Americans With Disabilities Enforcing the ADA," January 26, 1992 to June 27, 2000. <http://www.usdoj.gov/crt/ada/archive/pubs/reg3rpt.htm>
15. Pennsylvania General Assembly, "Act-148--AIDS-Confidentiality of HIV-Related Information Act," November 29, 1990. (Harrisburg, Pennsylvania, Pennsylvania Legislative Service, 1990) 427-435.
16. Ibid., 429.
17. Ibid.
18. CDC, "New HIV Counseling and Testing, and Referral Guidelines," 1.
19. Council on Ethical and Judicial Affairs, American Medical Association, "Code of Medical Ethics: Current Opinions with Annotations 2004-2006 Edition," (Chicago, IL: AMA Press 2004): 2.23, pp. 102-103.
20. Editorial, "New Guidelines for HIV Testing."
21. Peter A. Clark, "Mother-To-Child Transmission of HIV in Botswana: An Ethical Perspective on Mandatory Testing," *Developing World Bioethics* 6, 1, (2006) 1-12.
22. A. Grant, D. Jamieson, L. Elam-Evans et al., "Reasons

- for Testing and Clinical and Demographic Profile of Adolescents with Non-Perinatally Acquired HIV Infection,” *Pediatrics* 117 (March 27, 2006): 468-475.
23. Samuel Bozzette, “Routine Screening for HIV Infection-Timely and Cost Effective,” *New England Journal of Medicine* 352, 6 (February 10, 2005): 620-621.
24. Richard Perez-Pena, “HIV Tests Pose Choice of Breakthroughs,” *New York Times* June 6, 2005. <http://www.nytimes.com/2005/06/06/nyregion/06hiv.html>.
25. *Ibid.*
26. Matthews, 1.
27. Paltiel et al., 589.
28. Bozzette, 620.
29. Sanders, et al., 575.
30. Paltiel et al., 588.
31. Bozzette, 620.
32. *Ibid.*
33. Joseph Mangan, S.J., “An Historical Analysis Of The Principle Of Double Effect,” *Theological Studies* 10 (March, 1949): 41.
34. Gerald Kelly, S.J., *Medico-Moral Problems* (St. Louis, MO.: The Catholic Health Association of the United States and Canada, 1958): 13-14.
35. M. Schuster, R. Collins, W. Cunningham et al., “Perceived Discrimination in Clinical Care in a Nationally Representative Sample of HIV-Infected Adults Receiving Health Care,” *Journal of General Internal Medicine* 20, 9, (September 2005): 807-814.
36. Matthews, 1.
37. Bozzette, 621.
38. Bozzette, 621.
39. James J. Walter, “Proportionate Reason And Its Three Levels Of Inquiry: Structuring The Ongoing Debate,” *Louvain Studies* 10 (Spring, 1984): 32.
40. Premoral evil refers to the lack of perfection in anything whatsoever. As pertaining to human actions, it is that aspect that we experience as regrettable, harmful, or detrimental to the full actualization of the well-being of persons and of their social relationships. For a more detailed description, see Louis Janssens, “Ontic Evil And Moral Evil,” in *Readings In Moral Theology, No. 1: Moral Norms And Catholic Tradition*, ed. C.F. Curran and R.A. McCormick (Ramsey, NJ: Paulist Press, 1979): 60.
41. McCormick's criteria for proportionate reason first appeared in Richard McCormick, *Ambiguity In Moral Choice* (Milwaukee, WI.: Marquette University Press, 1973). He later reworked the criteria in response to criticism. His revised criteria can be found in *Doing Evil To Achieve Good*, eds. Richard McCormick and Paul Ramsey (Chicago, IL.: Loyola University Press, 1978).
42. Matthews, 2.
43. Santora, 2.
44. Fulbright, 1.
45. Santora, 1.

Author Information

Peter A. Clark, S.J., Ph.D.

Jesuit Community, St. Joseph's University