

# ETHICS

## ETHICS IN ACTION

### UNCONSENTED HIV TESTING IN CASES OF OCCUPATIONAL EXPOSURE

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An emergency medicine resident gets stuck with a visibly contaminated, large hollow-bore needle while attempting to insert a central line. The source patient is informed of the injury but refuses to provide consent for HIV testing. A year ago, this same EM resident became ill and had to be hospitalized after taking post-exposure prophylaxis (PEP) for a prior occupational exposure. She is concerned about taking PEP for the current exposure and asks if she can use blood already taken from the source patient for other reasons and test it for HIV.

Despite significant improvements in occupational safety standards in health care settings, these scenarios are all too common. In 2000 the Centers for Disease Control and Prevention estimated that approximately 385,000 needlestick and sharps-related injuries occur every year to health care workers in hospital settings.<sup>1</sup> In EM, a 1998 study of graduating residents found that 56% reported a potentially infectious occupational exposure.<sup>2</sup> The real number of injuries is likely much higher because most exposures go unreported.

Fortunately, in most cases of occupational exposure, source patients gladly give their voluntary consent for HIV testing once notified of the exposure. Yet, what should happen when source patients actively refuse or are unable to provide consent for additional testing? When source patients refuse or are unable to provide consent for HIV testing, exposed persons lack all the information they need to make a fully informed decision about initiating PEP.

The case vignette brings up the uncomfortable notion of testing source patients for HIV without their voluntary informed consent. At first glance, the practice of unconsented testing may appear antithetical to one of the core ethical principles of our profession: respecting patient autonomy. However, appealing to well-accepted deontological and consequentialist ethical principles and theories could potentially justify unconsented HIV testing in limited circumstances.

Deontological ethics focuses on the duties individuals have to one another. Often these duties can conflict with one another. Unconsented HIV testing after an occupational exposure is one such case where the duty to respect autonomy conflicts with the obligation to prevent harm to others. While controversial, interference with a patient's autonomy may be justified if the potential harm to a third party is significant. This "harm principle" is one justification that we use as emergency physicians to hold homicidal patients in the ED, quarantine those with highly infectious communicable diseases, and notify the partners of newly diagnosed HIV/AIDS patients. Unfortunately, no algorithm exists for determining when potential harms to a third party justify overriding an individual's autonomy.

Consequentialist theories, the most well-known of which is utilitarianism, require that beneficial consequences be maximized and harmful consequences be minimized. The consequentialist approach requires a calculation of the potential harms and benefits to all persons affected by the action or policy. In unconsented HIV testing, the harms and benefits to both source and exposed persons must be defined and balanced. If harms and benefits to the exposed person outweigh the harms and benefits to the source patient, unconsented HIV testing might be justified. Conversely, if a source patient would suffer a preponderance of harmful consequences that outweighed the benefits either to herself or to the exposed person, unconsented HIV testing would be morally wrong. As with deontological ethics, there is no magic formula for weighing harms and benefits.

Luckily, emergency physicians are not the only ones who have thought through these issues. As of September 2010, 35 states had enacted legislation to permit some form of unconsented HIV testing after an occupational exposure; however, there is no consistency among the statutes in different states.<sup>4</sup> Variability exists on when unconsented HIV testing may be allowed, who can

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authorize an unconsented HIV test, how the test results should be documented in the medical record, who is informed of the test results, who pays for the test, and how incidents of unconsented testing are recorded and examined for quality assurance. Some states require a court order for all cases of unconsented HIV testing, others allow unconsented testing only when a patient is comatose or otherwise incapacitated, while still others allow testing over a patient's autonomous objection.<sup>5</sup> Although no central repository for laws specifically addressing unconsented HIV testing in cases of occupational exposure exists, the National HIV/AIDS Clinicians' Consultation Center at the University of California, San Francisco has an excellent resource that can be used to look up your state's laws regarding HIV testing.<sup>4</sup>

**Case Resolution:** The ED attending had a conversation with the source patient to understand his reasons for refusing the HIV test. The patient revealed that he had participated in risky sexual practices many years ago and had overwhelming anxiety about being tested. He did not appear to fear, nor did there appear to be any risk of reprisals, violence, or discrimination that might result from the unintended disclosure of a positive HIV test. Despite the attending's best efforts to explain the importance of the HIV testing, the patient continued to refuse. Although the ED attending felt that, based on the risks and benefits, there was ethical justification for performing an unconsented HIV test, ultimately no test was performed because state law prohibited unconsented HIV testing over a patient's autonomous objection. ▀

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