ETHICS IN ACTION

A DUTY TO WARN

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A well-appearing middle-aged female patient presents to your emergency department following a suicide attempt. The Poison Control Center recommends that the patient be observed for 4-6 hours to monitor for any further deterioration, and a 72-hour psychiatric hold is placed on her. Her toxicological workup is negative for acetaminophen and salicylates, and she remains alert and well appearing, and has no lab abnormalities during her observation period. The patient's husband arrives at the emergency department and remains present at the patient's bedside.

Your emergency department has psychiatric social workers who help facilitate the disposition of patients from the ED into a psychiatric facility, and you consult them to evaluate this patient, as you anticipate she can safely be discharged within a few hours to psychiatry. At the same time, several of the nurses change shifts, and a new nurse assumes care of the patient.

The patient's oncoming nurse and the psychiatric social worker both recognize the patient's husband immediately. He was seen in the emergency department within the last week, and is known by many of the staff. They also know that he is HIV-positive. Both the nurse and the social worker come to you with concerns that the patient likely does not know this information, because she did not endorse this as part of her past medical history. They are unsure how to proceed. What should you do?

Obviously, before contemplating any intervention in a case like this, one must be sure the person in question actually is HIV-positive. In this scenario, the patient was well known to the emergency department staff and there was little concern that this was not the case; however, this should be the first priority.

As a physician, what is your responsibility to your patient? Are you allowed to notify your patient that she has a risk of being HIV-positive? This is commonly referred to as "a duty to warn." Should patient-doctor confidentiality be maintained if it is potentially putting someone else at an immediate risk of danger?

The answers to these questions are largely state-dependent, as each state has its own laws regarding how to proceed in this scenario. For instance, the Ohio Revised Code states that "the results of an HIV test or the identity of an individual on whom an HIV test is performed or who is diagnosed as having AIDS or an AIDS-related condition may be disclosed only to the following: the individual who was tested or the individual's legal guardian, and the individual's spouse or any sexual partner." Note that the law reads that the results may be disclosed. It does not state that the results must be disclosed. Some states and cities have partner notification laws that mandate that if someone tests positive for HIV, they or their health care provider must tell sex or needle-sharing partners. Some health departments also require providers to report the names of partners as well, even if the patient refuses to report the information on their own.

Regardless of the specifics of the local laws, most states require that all HIV-positive results be sent to the state's health department, and this has many beneficial public health consequences. The health department will then send along this information, de-identified, to the CDC for the purposes of monitoring trends. The state health department can be involved in tracking down sexual contacts for notification purposes. The Ryan White HIV/AIDS Program requires that any health department receiving money from their program show "good faith" efforts to notify marriage partners of a patient with HIV/AIDS.

A further question that arises is whether or not an HIV-positive person who knowingly exposes another person to HIV is engaging in criminal behavior. Most states have passed laws that criminalize the exposure of a partner to HIV. Between 1986 and 2001, 316 people were prosecuted for exposing others to HIV, according to the Criminal Law and Policy Project. Many of these laws were developed prior to HAART therapy, which significantly diminishes the transmission of HIV. Some HIV advocacy groups, as well as the Obama administration's National AIDS Strategy, released in July 2010, have recommended that these laws are outdated, and that they "may make people less willing to disclose their status by making people feel at even greater risk of discrimination."

What of the initial question? What are we permitted or obligated to tell our patient? In states that require or, alternatively, do not permit, revealing results to partners, the answer is straightforward. Where the decision is up to the provider, that is, where he or she may, but need not, inform partners, matters are more difficult. This decision is difficult, and several patient factors may play a role in it. For instance, a patient who is no longer sexually active with the infected partner may conceivably be at lower risk of contracting HIV in the future compared to one who is still with their partner. In a patient who has limited access to follow-up care, telling them in the emergency department may help facilitate follow-up appointments with infectious disease specialists. Some

emergency departments, including ours, have an infrastructure in place to help counsel and arrange follow-up for patients who test positive for HIV, such that a provider on a busy shift could still assure timely care for these complicated patients.

If the decision is made to tell the patient of their exposure, the provider should also be prepared to test the patient for HIV. If an individual tests positive for HIV, providers should be comfortable explaining the positive test result and the nature of HIV, and should be able to provide resources for medical treatment, social services, and possibly counseling. Patients who test positive for HIV should be informed on the importance of preventing transmission to others as part of their post-test counseling.

In the case at hand, the ED staff first attempted to encourage the patient's husband to disclose his HIV status to the patient. When he did not oblige, the legal and ethics team on call were consulted, and recommended notifying the patient of her husband's status. An HIV test was performed on the patient following notification, and was negative. ◗

REFERENCES FOR INDIVIDUAL STATE LAWS:

http://www.hivdent.org/_uspublicpolicy_/USPP_SCSOHT_2005.htm
http://www.cdc.gov/hiv/policies/law/states/exposure.html
Acknowledgments: Caitlin Schaninger provided assistance with this article.

DIVERSITY AND INCLUSION

ADIEM/SAEM MEMBERS WELL REPRESENTED AT THE AAMC HEALTHCARE EXECUTIVE DIVERSITY AND INCLUSION CERTIFICATE PROGRAM

Bernie Lopez, MD, MS, CPE, FACEP, FAAEM
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The SAEM Academy for Diversity and Inclusion in Emergency Medicine (ADIEM) continues to engage in leadership opportunities addressing diversity and inclusion in the United States. We know that, although the US population continues to become more diverse, the medical workforce has not kept pace. We also know that the benefits of a diverse and inclusive health care environment have been well described, and contribute to reducing the health inequities seen across the country. While efforts are being made at most academic institutions to enhance the focus on diversity and inclusion, it requires a significant investment in the education and training of leaders to drive the process.

Nineteen diversity leaders in a variety of medical specialties from across the country participated in the American Association of Medical College (AAMC) Healthcare Executive Certificate Program in Diversity and Inclusion from January to June of this year. This is a six-month intensive academic program of diversity education specifically designed to develop the competencies leaders need to drive diversity as a core component of excellence in health care. The program consisted of a formal curriculum that combined distance-learning through series of webinars and interactive projects and three weeks of in-residence study with a focus on acquired knowledge and applied skills.

Of the nineteen participants, the predominant specialty was emergency medicine, as four SAEM members completed the program: Yolanda Haywood, MD, associate professor of emergency medicine and associate dean for student affairs and diversity and inclusion at George Washington University School of Medicine; Marquita Hicks, MD, associate professor of emergency medicine and director of community engagement in the Office of Diversity and Inclusion at the University of Alabama at Birmingham School of Medicine; Ava Pierce, MD, associate professor of emergency medicine and faculty liaison for Housestaff Emerging Academy of Leaders (HEAL) at the University of Texas Southwestern Medical School; and Bernie Lopez, MD, MS, professor and vice chair of emergency medicine at Thomas Jefferson University Hospital and associate dean for diversity and community engagement at the Sidney Kimmel Medical School of Thomas Jefferson University. Three of the participants — Drs. Hicks (Awards Committee), Pierce (Development), and Lopez (president-elect) — serve as executive board members for ADIEM.

(from left to right): Marquita Hicks, MD, Yolanda Haywood, MD, Bernie Lopez, MD, MS, and Ava Pierce, MD.

This accomplishment serves as further evidence of the dedication of ADIEM members in promoting diverse and inclusive environments not only in emergency medicine, but in the house of medicine in general. This further promotes health equity and the provision of optimal health care to all that we serve. As we continue to move the needle on diversity and disparities in EM, we encourage you to join us. We continue to do important work and welcome your engagement. ◗