

Position on HIV Testing
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I would like to introduce myself to you and thank you for the opportunity to speak. I have been an HIV primary care provider since 1987 when I started working as an internist in private practice in Amsterdam, the Netherlands. I have been caring for HIV-infected people since then, and for the last 14 years I have been practicing in Philadelphia. For the last 4 years I have been deputy director of Temple's Comprehensive HIV Program. I do primary care, HIV specialty care and HIV research at Temple University.

Let's start by looking at what is now known about the HIV epidemic in the United States and in Pennsylvania in particular. As of 2000, there have been about 40,000 new infections yearly in the United States. All of these infections are virtually preventable, whether the source of infection is by sexual contact, blood transfusion, use of needles, or by what we call perinatal transmission (which is HIV-positive mother-to-child-transmission while the mother is pregnant). To be preventable simply means that the person who is HIV-infected knows his or her status, and that he (or she) takes measures not to spread the virus; and for those who don't know their status, to act in such a way to make any transmission next to impossible. The most important source of infections in the world is heterosexual transmission. The most important source of infections for Pennsylvania are mixture of intravenous drug abuse, homosexual and heterosexual transmission; for women in Pennsylvania (and the US) living with HIV infection, 78% of them acquired HIV through heterosexual contact. The virus doesn't care how it is acquired. However, we know with great certainty how it can be avoided.

It has been estimated that there are about 1 million HIV-infected people living in the United States today, and only one quarter of these people know that they are HIV positive. About one half of these people with HIV are found out late into their illness when they get ill and develop AIDS, mostly 8-10 years after getting infected. Among 4,127 people with AIDS reported from 16 states in 2000-2003, 45% were first diagnosed HIV-positive within 12 months of AIDS diagnosis, meaning that they were tested late in their illness. This is important because HIV infection typically exists for years in a person before it is detected. Late testers in this study compared to those tested earlier (>5 yrs before AIDS diagnosis) were more likely to be younger (18-29 yrs), heterosexual, less educated, African American or Hispanic. Who is most likely to be having sex in our society—younger people! Less educated people might not know how to protect themselves from HIV by using condoms. Remember only 25% of HIV-infected people in the US actually know that they are infected.

HIV-infected people can spread the disease more efficiently when the amount of virus in the blood is high. Toward the beginning of HIV infection before the body exerts control over the virus and at late stages of illness when the virus is rapidly growing and the body has failed to control it, the amount of virus is the highest it will be in the blood of the HIV-infected person. Therefore, the transmission of virus from one person to the

next can occur the most efficiently in “newly diagnosed” people and in late stage people. We also know that people who test positive for HIV change their behaviors to reduce likelihood that they spread HIV. In the case of sexual transmission, that means they are more likely to wear a condom. Research has shown that the 75% of HIV-infected people who know their status account for ~30-46% of new HIV infections yearly; while the 25% of HIV-infected people who are unaware they have HIV are responsible for the spread to 54-70% of new infections yearly. Spread is also less likely for heterosexual transmission and mother-to-child-transmission if HIV infection is successfully treated by medications. Sometimes doctors recommend delivery of the baby by Cesarean section (C-section) as it reduces the exposure of the baby to HIV while being born if the laboring mother still has detectable virus in her blood or is very late at getting into HIV care. (Think of being born as one HIV exposure episode for the baby in the birth canal.) But in order to treat the virus in any given person, that person has to be tested first. We have to test more people in the US with the goal of getting each and every HIV-infected person into care. That is what the CDC is interested in. To test all people in the US between the ages of 13 and 64 years to help stop this epidemic.

Testing all people might sound like too many tests. The reality here is that targeting testing of people whom providers think are at risk for HIV has turned out to be a failure. Most HIV tests are being done in private doctors offices in the US; much fewer tests are being done in places such as STD (sexually transmitted disease) clinics where risk would be higher than in a routine clinical setting as the person is coming in after having unprotected sex, and is coming in for an STD check. In addition, research has shown that people who test positive generally didn't think that they were at risk at all for catching HIV. Increasing HIV testing and making it part of routine care would reach all people.

Finally, treating HIV is very different now than when Act 148 was enacted. In the beginning, we doctors basically helped our patients die; now, we help them live longer and longer. The types of medications used and treatment regimen choices have increased to such a point that many patients can treat their HIV with “one pill a day.” Our medical outcomes continue to improve as more potent treatment regimens come into use. We can say to a desperately ill person with AIDS today that if that person gets into care and takes the medications, that person will become with time a healthy person living with AIDS. In the 1980s, the life expectancy after diagnosing someone with AIDS was 18 months from diagnosis of AIDS until death; now, the life expectancy after an HIV diagnosis can be measured in decades — if people get care and treatment for HIV. In addition, once that person is treated and the virus in the body goes down to undetectable levels, the chance that the virus can spread to others goes way down. This is the treatment principle behind treating pregnant HIV-infected mothers — to get her virus level down in order to help protect the developing baby from getting her HIV infection. But that pregnant woman has to be tested for HIV first.

This is why I am in favor of changing the law in Pennsylvania. It is unduly cumbersome. It places the health care provider in a position to ask for written informed consent for a blood or oral swab test, which in itself is promoting the stigmatization

around HIV. It also requires a notion of pre-test and post-test counseling which is nothing more than, for those who test negative, counseling in harm reduction (safe sex, abstinence, not using intravenous drugs). For those who test positive, post-test counseling is a misnomer and has to do with getting that person into further care in addition to harm reduction counseling. Pennsylvania law does not require face-to-face encounters for HIV pre-test counseling; however, most providers have interpreted the Act 148 with having a requirement for face-to-face encounter for pre-test counseling because of the written informed consent requirement—the providers could give out written information about HIV and HIV testing, and then have the person sign the informed consent. Post-test counseling and disclosing the HIV test results must be done face-to-face with the provider even when the HIV results are negative. Certainly if it is negative, a telephone counseling session would be sufficient. I feel it is similar to doing a Pap smear in a female patient. Most providers would call with the results. If it is normal, a phone call can be made; if it shows cancer, most providers would ask the patient to come in for a repeat test and not say over the phone that it showed cancer. Legislating face-to-face encounters does not equate delivering better care or counseling. We need to increase testing for HIV, and test all people 13 to 64 years-of-age in the US for HIV as recommended by the CDC. Removing the burden for requiring face-to-face posttest encounters by law would increase testing for HIV. Removing the written informed consent requirement would increase testing for HIV. Consenting can be done by verbal consent as it is done for all other types of routine testing such as cholesterol testing. Several states have already gotten rid of written informed consent requirements; in the case of California, the HIV testing rates have gone up.

Now for a few remarks about addressing privacy concerns. I agree with all speakers here that it is paramount to protect the privacy of HIV-infected patients, and there is still discrimination against and stigmatization of HIV-infected people. However, current provisions now in place to protect all health information (HIPAA laws) are sufficient to protect the privacy of HIV-infected people.

In conclusion, in order to help stop the HIV epidemic in the US, all people 13 to 64 years-of-age need to be tested for HIV as recommended by the CDC; targeted testing for HIV has proven to be a failure. Newly diagnosed HIV-infected people account for most of the new infections transmitted by unprotected sex (sex without a condom) in the US. Most people infected with HIV didn't think that they were at risk for catching HIV. Finally, people who know that they are HIV-infected reduce behaviors that promote HIV transmission; in other words, they tend to wear condoms more consistently. Treating people for HIV prolongs their lives and also make subsequent chance of transmission of HIV to others less likely.

Now I would like to talk to you about some of my patients who have become HIV-infected. These people might not have become infected if those who infected them knew their HIV status and changed their own behaviors. I thank you for your time.

Mrs. S

- 79 year old woman brought in by her daughter for weight loss
- Work-up “appropriate for age” was negative
- Daughter urges HIV and STD testing
- “I don’t trust her new boyfriend”
- She didn’t worry about birth control at her age
- “They had to tie me down when they told me”
- She only disclosed to the one daughter
- She later died of esophageal cancer

Miss G

- 30 year old woman presented to ER after being kicked down the stairs by current boyfriend
- No prenatal care, no HIV testing previously
- HIV positive at the hospital
- She went into labor, delivered 2 weeks early by C-section
- Baby is HIV positive

Mr. P

- He was diagnosed with lyme disease as an outpatient with fever and a rash
- Stable monogamous relationship
- Persistent low white blood cell counts
- HIV positive-total surprise
- Mrs. P now in care and HIV negative

Mr. L

- Newly divorced man, 53 years old
- Wants to get checked out for everything
- Wants full STD check
- This requires 2 visits, 2 copays
- Does not worry about birth control with what he considers “older women”