# HIV testing of patients: Let's waive the waiver

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At the CMA's 1999 annual meeting, the following motion was put before General Council: "That the CMA recommends that patients undergoing any procedure where a health care worker could be accidentally exposed to the patient's bodily fluids be required to sign a waiver that would allow appropriate testing of the patient's serological status of HIV and hepatitis if such exposure should occur, while ensuring patient confidentiality." After a vigorous debate, the resolution was passed by roughly a 2-to-1 margin.

In principle, this is a well-intentioned attempt to assist health care workers with the trauma associated with accidental occupational exposure and to provide guidance about the possible use or avoidance of prophylactic antiretroviral therapy. Unfortunately the resolution is vague, impractical, detrimental, pointless and unnecessary. Although we will concentrate our comments on HIV infection, even stronger arguments could be raised for hepatitis C, for which transmission dynamics are poorly understood and prophylaxis is unavailable.

Why vague? It is difficult to think of any procedure during which accidental exposure to a patient's bodily fluid could not occur. If taken to the extreme, almost everyone who visits a family physician, an emergency department or a community laboratory would have to sign a waiver. Clearly, the decision to obtain a waiver cannot be based on arbitrary criteria imposed by those who perceive they may be at risk. Furthermore, the policy does not describe what type of exposures would trigger testing. Without clear criteria, such a directive could send the wrong message and lead to inappropriate testing after even the most minor exposure.

Why impractical? Many of the highest risk procedures are performed in emergency situations or intensive care units, where the opportunity to obtain a patient waiver may not be possible. During a medical crisis it would be inappropriate to approach the patient or a family member about signing a form regarding HIV testing in the unlikely event that a health care worker might be exposed to their bodily fluids.

Why detrimental? First, raising the issue of serologic testing is not necessarily a benign process. It is one thing to approach those few patients after an accidental exposure has occurred; it is quite another to approach the hundreds of thousands of patients before procedures during which exposure could theoretically occur. Second, any directive that increases the number of people tested who are at extremely low or no risk will lead to increased numbers of false-positive results. Currently, one might expect about 5

positive enzyme-linked immunosorbent assay (ELISA) results per 1000 tests on the basis of Red Cross and national testing data. Most of these will be false-positive results, but confirmation is possible only days or weeks later with the Western blot at designated reference laboratories. What of the anxiety to the patient and the health care worker in the intervening period?

Why pointless? The vast majority of patients will sign the waiver. No problem there. But what of those who will not? Surely, the CMA is not suggesting that these patients be denied a medically necessary procedure on this basis? Counselling guidelines published by the CMA in 1995 state clearly that "testing for HIV is not compulsory in Canada. Therefore it cannot be imposed in any circumstance."[1] The Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care, approved by the CMA Board of Directors in December 1998, states as its first principle that the "needs, values and preferences of the person receiving care should be the primary consideration in the provision of quality health care."[2] If the procedure is performed anyway, what exactly has been achieved? Any argument that more stringent precautions would be put in place for those who refuse would fly in the face of universal precautions, which are meant to prevent the transmission of known and unknown blood-borne pathogens in all instances.

A second element of pointlessness stems from the issue of proper counselling and informed consent. It is universally agreed that HIV testing must be accompanied by proper counselling before and after testing. With the waiver policy, the pretest counselling would have to be provided either when the waiver is proffered or when the blood is drawn for testing after an accidental exposure. One purported advantage of a waiver is that blood could be drawn from an anesthetized patient immediately after an operation during which an exposure has occurred, rather than waiting several hours to obtain informed consent. The feasibility, let alone the sensibility, of providing proper pretest counselling to the myriad of patients before all invasive procedures is dubious in the extreme. It follows that the pretest counselling would occur after accidental exposure. The patient, now presented with all the information about the test for the first time, must have the right to refuse testing, waiver or no waiver. As the CMA counselling guidelines state, "Although most patients are likely to consent to testing for HIV, some may refuse. … Ultimately, refusals should be respected."[1] This, in effect, renders the waiver moot.

Finally, and perhaps most important, is the policy necessary? Currently at our hospital there are on average about 120 accidental occupational exposures per year that are sufficiently serious to warrant antiretroviral prophylaxis, and many more for which prophylaxis is not used. During the past decade an estimated 1700 accidental occupational exposures occurred. The hospital protocol is such that every source patient is asked to consent to HIV testing (except those already known to be HIV positive). During the 10 years, there have been only 2 instances in which the source patient refused to be tested in our setting (Dr. Alastair McLeod, personal communication, December 1999). We suspect that this mirrors experiences at other hospitals across the country. This begs the question, "If it ain't broke, why fix it?"

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## References

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2. Canadian Medical Association. *Joint statement on preventing and resolving ethical conflicts involving health care providers and persons receiving care*. Ottawa: The Association; 1998 Dec 4–5. [Available: www.cma.ca/inside/policybase/1998/12-04.htm#princ]

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