Wrath of God syndrome, Gay-related Immuno-deficiency Syndrome, Gay Cancer, Gay Plague—these are the names AIDS had in the 1980s. False myths made uninfected people afraid to interact with affected individuals. A political cartoon of these times bitterly made fun of the prevailing attitude towards the disease, "It affects homosexual men, drug users, Haitians and hemophiliacs...Thank goodness it hasn’t spread to human beings yet" (Black, 1985).

After more than 20 years, AIDS is still a huge issue but the statistics and attitudes have changed. Even though men having sex with men (MSM) are still the majority of carriers, more and more new infections arise through heterosexual intercourse, especially among women and adolescents (Centers for Disease Control and Prevention [CDC], 2005). With the development of potent highly active anti-Retroviral therapy (HAART), AIDS is turning into a chronic disorder, so HIV-positive people live longer and meaningful lives. Unfortunately, no cure is on the horizon, and the pandemic is far from being controlled. More cases are being detected and treated in the U.S., but the number of new infections is not going down (Centers for Disease Control and Prevention, 2005).

With the appearance of fast HIV testing kits, large-scale screening for the virus became possible. Previous CDC recommendations were to test individuals at high risk for the infection, based on behavioral, lifestyle and social factors (so-called targeted screening), as well as those presenting symptoms. However, in September 2006, the CDC released new recommendations that encouraged “broad-based testing for patients ages 13 to 64 in all health care settings after the patient is notified that testing will be performed unless the patient declines (opt-out screening)” (CDC Fact Sheets, 2006). The rationale behind this is that turning the HIV test into a routine procedure will decrease the stigma of the disease and increase the probability of starting treatment at the early stages of the syndrome. MSM who are aware of their HIV status tend to engage less in risky behaviors that can promote the spread of the infection (Marks et al., 2005). Since the CDC reports that 48% of MSM are infected but don’t know about it, an increased awareness of one’s status is very important. Moreover, routine universal screening is more cost-effective than treating the advanced disease and opportunistic infections (Bozzette, 2005). This strategy has already proved successful in a specific population—pregnant women—where routine prenatal screening significantly reduced the rate of mother-to-child HIV transmission (Branson et al., 2006).

Nevertheless, the path to the implementation of these guidelines is long and contains several obstacles. First, many state laws (New York is not an exception) require special consent forms for HIV testing, and it will take a while for those laws to be reversed. Apart from the legal component, many social movement leaders, such as Rose A. Saxe, a staff lawyer with the AIDS Project of the American Civil Liberties Union, fear that the lack of consent forms and pre-test counseling will turn a routine test into a mandatory test, without patients realizing they can opt out (McNeil, 2006). That becomes very relevant if we keep in mind that emergency rooms are the main locations where broad screens can be performed—and emergency rooms are where doctors are most short for time. In states where HIV prevalence is low, such a general screen seems to be a waste of money and time.

What about the psychological and ethical aspects? These are where the most heated argument is nested. It is hoped that making HIV testing routine will eliminate the remaining stigmatization; patients would be more willing to be tested when they are among everyone else, rather than singled out for different reasons. But a routine test is more prone to inappropriate disclosure, and without additional pre-test procedures patient confidentiality becomes a bigger concern. In her interview, Ms. Saxe also points out that teenagers “will be tested without an opportunity for understanding the magnitude of having a positive result” (McNeil, 2006). That is where a weak spot in the proposed recommendations comes out. A diagnosis of HIV infection can have profound psychosocial effects, including the risk of suicide, and the CDC recommendations fail to ensure that the patient receives proper post-test counseling and treatment (Gostin, 2006).

So a lot is up to the health-care providers to figure out. Emergency departments are so far the main focus of pilot studies on the effectiveness of broad-based, opt-out screening, but ideally universal screening should spread beyond that. Rumors have it that New York City is going to implement a borough-wide HIV testing of the Bronx population. No matter how scary the statistics turn out to be, we must face the truth. HIV is a persistent problem. No cure has been found, so education and prevention should be emphasized. It is very prom-
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ising that the CDC is trying to improve the situation, but it will take the cooperation and understanding of everyone else to make it a huge team effort at fighting the spread of the vicious virus.

REFERENCES


