Author's response to reviews

**Title:** Understanding Patient Acceptance and Refusal of HIV Testing in the Emergency Department

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**Author's response to reviews:** see over
Editors’ Comments

Please add context information to the Background section of the Abstract.

We have added this information.

Response to Reviewers

Reviewer 1 (Dr. Haukoos) has no suggested revisions.

Response to Reviewer 2 (Dr. Wanyenze)

Major Compulsory Revisions

1) The concept of repeat testing within provider initiated testing in health facilities needs to be developed further. Patients who have chronic illnesses and present to health facilities frequently may be tested repeatedly even when they do not need repeat testing. When they decline, this exaggerates the rate of decline. Yet testing may not be necessary for them. When should they be retested?

The reviewer raises an important point. CDC guidelines are to test all high-risk persons at least annually and that repeat testing of individuals not at high risk is on the basis of clinical judgment. However, one of the implications of “routine” HIV testing is that testing is offered regardless of risk factors. It is true that low-risk individuals may not require re-testing and that their refusal may make it more difficult to interpret refusal rates. This is further supported by our finding that recent testing with an HIV negative test result was the most common reason for refusal of HIV testing in the ED. We have incorporated this point into our limitations section, as we did not ascertain when participants had last tested.

2) Whereas it is important to understand the reasons for refusal and to identify mechanisms of increasing acceptance of testing in health care settings, it is important to recognize that patients still have the right to decline testing for whatever reason, and to test later or not at all, if they do not wish to do so.

We agree with this point and have incorporated it into our conclusions.

3) Other than convenience and the test being free, it seems most of the reasons for accepting the test are similar to the reasons why people seek testing in client initiated/VCT settings.

We concur that the perception of being at risk for HIV infection is a reason for either seeking testing in a VCT setting or accepting the offer of testing in a health care setting. We have incorporated this point into the discussion.
Minor Essential Revisions

1) At the beginning of the Methods section, it is better to include the exact number of respondents who accepted and refused, as presented in the abstract.

We have made this change.

2) It was difficult to recruit patients who declined from the site where clinicians offered the test. May be useful to further describe why this was difficult. Is it that few individuals declined a test when introduced by clinicians? If so, this may need to be discussed in relation to approaches for increasing uptake and ensuring informed consent. This phenomenon has been observed elsewhere but is not well understood.

It is not clear whether recruitment was more difficult at this site because fewer patients declined or because referrals at this site had to come from busy ED clinicians, who had multiple competing priorities. Even if a patient may have refused a test, the ED clinician may have been too busy to refer patients to the interviewer. We have added this information to the results and limitations section.

3) 82% of those who declined testing had previously tested. Did the study establish when they last tested? Depending on when their last test was done and their risk behavior history, repeat testing may not be necessary. It’s possible therefore that the refusals are over-estimated if individuals who may not be eligible for testing are included. It may be useful to describe the testing approach in these facilities a little more – for example, are all people who present to the ED tested even if they have tested in a few weeks months? Is there a guide to repeat testing? If so, what does it recommend?

We did not establish when patients had last tested in any systematic way. At the time this study was done, the EDs did not have formal policies on repeat testing. Please see our response to Point 1 under Major Compulsory Revisions. We agree that this is an important area for future research and have indicated so in our discussion.

4) In Table 1, both the patients who declined and those who accepted testing are combined. Might have been better to present them separately, like was done in Table 2.

We believe that presenting the demographics and health care utilization characteristics of decliners and accepters separately could be misleading, as this study was not a comprehensive attempt to describe the ED testing population.

5) Limitations: Include exclusion of patients who tested positive?

As being diagnosed with HIV in the ED represents a different kind of testing experience, we believe it was beyond the scope of this study. Moreover, recruiting participants into an in-depth interview study at the time of HIV diagnosis would be challenging and potentially insensitive.